Contract Committee Meeting
August 17, 2022 5:30 PM
Central Services Board Room

1. Call to Order - Mrs. Teresa Boston
2. Moment of Silence - Mrs. Teresa Boston
3. Approval of Meeting Minutes
4. Interquest Detection Canine Agreement
5. Uplands Design Group AIA Stone Elementary Roof
6. Uplands Design Group North Electrical Amendment
7. United Healthcare Services Billing Contract
8. Other Discussion
9. Adjournment

Contract Committee Meeting July 26, 2022
Central Services Board Room

The Contract Committee met on Thursday, July 26, 2022, in the Central Services Board Room where Mrs. Teresa Boston called the meeting to order at the approximate hour of 4:30 p.m. She welcomed everyone to the meeting and appreciated everyone for attending.

PRESENT:

Mrs. Teresa Boston, District 8, Chair
Mrs. Rebecca Hamby, Dis 7
Mr. Jim Inman, Dis 1
Mr. Robert Safdie, Dis 2
Mr. Earl Patton, Board Attorney
Dr. Rebecca Farley, Pre-K-Elementary Supervisor
Mrs. Marsha Polson, Coord. School Health Supervisor
Mr. William Stepp, Director of Schools
Mo Charnot, Media

1. **Call to Order – Mrs. Teresa Boston**
2. **Moment of Silence/Pledge of Allegiance – Mrs. Teresa Boston**
3. **Approval of minutes – Hamby made a motion to approve the minutes.**

VOICE VOTE: Hamby (mover-yes) Safdie(seconder-yes)

All Ayes

MOTION: Carried Unanimously

4. Educational Resource Management Consortium and Invoice
Boston introduced the first contract. She made a motion to approve and Hamby with a second. At discussion, Boston asked where this comes in at? Stepp informed the committee that this was ESSER money, and it pays for the audit that each county must do for the expenditures. Boston asked if this would come out of ESSER money and Stepp replied that it will. Boston asked if they would get a report and Stepp replied yes there would be a report and it also has to go to the state department. No further discussion.

VOICE VOTE: Boston (mover-yes) Hamby (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

5. MOU with CCS and Dr. Lauren Fox-Bergvin
Boston introduced the contract. Safdie made a motion for approval. Hamby made the second. Atty Patton asked if this physician actually supervised our nurses to which Polson replied, in a way they do in this situation. Patton asked if she was charging for these services and Polson replied no, she is not. Boston asked if that was her choice. Polson said it was her choice to provide those services to the school district. Safdie brought up the fact that in years' past there have been several physicians to give of their services on a volunteer basis. Polson said that when

former physicians retired, Dr. Bergvin agreed to be the consulting physician for the district. Polson pointed out that she has to have order for epi-pens, Narcan and things of that nature. Boston asked about liability. Patton said it does not increase liability. He said he would suggest that pro-bono be a clause in this agreement. Safdie asked how to go about doing that. Patton said he could reach out to Bergvin. Boston asked if Safdie would amend his motion and he replied yes. Boston said the atty will contact Dr. Bergvin and amend the contract.

VOICE VOTE: Safdie (mover-yes) Hamby (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

6. MOU with CCSD and Avalon Center

Boston introduced this contract Hamby made a motion to approve. Safdie with a second. He said the curriculum has to be approved by the state. Boston asked Stepp to confirm. Stepp said that because they were developing their plan through the state educational standards he didn't realize we would have to resubmit all items to the state. Polson said they are utilizing On Point curriculum which is our curriculum that's in place and approved by the state. Boston asked if they came in every school. Polson replied yes. No further discussion.

VOICE VOTE: Hamby (mover-yes) Safdie (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

7. TDOE Educator Preparation Agreement

Boston introduced this. Hamby made a motion to approve. Boston with a second. Safdie asked Dr. Farley how this was implemented last year. Farley told him they reach out to her and see what field, as the need is presented, they need to be placed. She then checks with a school that is willing to accept that student and that is their placement. Safdie asked if the state was fully funding this and Dr. Farley replied this was through Western Governs University, so it was no charge to the district. He then asked if we had any opportunity to get feedback from teachers on the effectiveness of the program. Farley said no, she had not. Stepp offered that during the time he had worked in this program and through this process, it was no problem at all and was a very good experience. Safdie asked if the DOS would get information on how many teachers are involved, the success of the program and the impact and evaluation of this program.

VOICE VOTE: Hamby (mover-yes) Boston (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

8. TNTP Math Implementation Support Grant Contract

Boston introduced the contract. Hamby made the motion to approve and Safdie with the second. Upon hearing no discussion this was approved to go to the full board on Thursday.

VOICE VOTE: Hamby (mover-yes) Safdie (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

9. Stellar Therapy Administrative and Clinical Services Agreement
Boston introduced this contract and told everyone this was a renewal that had been done every year. Hamby made the motion for approval and Safdie with the second. After no discussion it was approved to send to full board.

VOICE VOTE: Hamby (mover-yes) Safdie (seconder-yes)
VOICE VOTE: All Ayes
MOTION: Carried Unanimously

10. Other Discussion
Safdie wanted to explain that he though WGU would contain a teacher training component but not for student training, but for actual teachers. He said he was incorrect on that assumption to which Stepp responded correct.

8. Adjournment
Boston said she would entertain a motion to adjourn. Hamby made the motion and Safdie with a second. Meeting adjourned.

VOICE VOTE: Hamby (mover-yes) Safdie (seconder-yes

VOICE VOTE: All Ayes
MOTION: Carried Unanimously

(The meeting was adjourned at the approximate hour of 4:53 p.m.)

_____
Mr. William Stepp
Director of Schools

_____
Mrs. Teresa Boston
Chairman of the Contract Committee

_____

Diane McCartney
Executive Assistant for the Director of Schools and BOE

Interquest Detection Canines®
(INTERQUEST)
(Cumberland County School, Tennessee)
(The District)

This shall serve as an agreement by and between Interquest Detection Canines® and the DISTRICT for substance awareness and detection services for the period of August 2022 through May 2023.

It is understood that the DISTRICT has established and communicated a policy clearly defining contraband as all drugs of abuse (in the broadest terms), alcoholic beverages, firearms and ammunition, prescription and over-the-counter medication, and that this policy has been disseminated to all campus locations. Violations are considered inimical to the welfare of students and contrary to the DISTRICT'S desire to foster an atmosphere conducive to safety and education.

INTERQUEST shall provide contraband inspection services utilizing non-aggressive contraband detection canines. Such inspections may be conducted on an unannounced basis under the auspices and direction of the DISTRICT administration with INTERQUEST acting as an agent of the DISTRICT while conducting such inspections. Communal areas, lockers, gym areas, parking lots (automobiles), grounds, and other select areas as directed by DISTRICT officials, shall be subject to inspection. Contraband detected on DISTRICT property is the responsibility of the DISTRICT. Suspected drugs of abuse may be field-tested to provide preliminary or presumptive identification of the drug.

INTERQUEST agrees to provide **2 0 f u l l** day visits for the contract period (between August 2022 through May 2023). The DISTRICT may increase the total number of visits by notifying INTERQUEST in writing. Each full day visit will be **$550.00.** Multiple canine teams will be charged on a per team basis. DA required court testimony on behalf of the DISTRICT will be charged at the same rate. INTERQUEST will invoice for service on a monthly basis at the conclusion of the service month. The DISTRICT agrees to pay for services within thirty (30) days of receipt of such invoice.

INTERQUEST will schedule DISTRICT visits in conjunction with days designated by the DISTRICT as appropriate for visits. The District will provide a school calendar with inappropriate dates for service noted. This calendar will serve as an addendum to the Agreement. All other dates will be considered acceptable for visits. DISTRICT will be responsible for payment for any visit made on any day other than those days noted as unacceptable on the attached school calendar.

Both parties shall indemnify and hold harmless each other against from any and all claims arising from either's actions or performance under the terms of this Agreement. Each shall indemnify and hold harmless the other against and from any and all claims arising from any acts, negligent or intentional, arising from the performance of this Agreement or by any officer, agent, employee, guest, or invitee of either party, and from all costs, attorneys' fees and liabilities incurred in or about the defense of any claim or any action or proceeding brought thereon.

INTERQUEST is licensed and registered by the U.S. Department of Justice, Drug Enforcement Administration, Texas Department of Public Safety and the Texas Commission on Private Security, c-05527 and other state regulatory agencies as required..

INTERQUEST DETECTION CANINES® FOR THE SCHOOL: Cumberland County School District

_____ DATE:_____

Rocky S. Montgomery
President – Interquest Detection Canines of Tennessee

AIA® Document B104™ – 2017

Standard Abbreviated Form of Agreement Between Owner and Architect

AGREEMENT made as of the Twenty-Sixth day of July in the year Two Thousand Twenty-Two
(In words, indicate day, month and year.)

BETWEEN the Architect's client identified as the Owner:
(Name, legal status, address and other information)

Cumberland County Schools
368 Fourth Street
Crossville, TN 38555
Telephone Number: (931) 484-6135
Fax Number: (931) 484-6491

and the Architect:
(Name, legal status, address and other information)

Upland Design Group, Inc.
P. O. Box 1026
362 Industrial Blvd. (38555)
Crossville, TN 38557
Telephone Number: 931-484-7541
Fax Number: 931-484-2351

for the following Project:
(Name, location and detailed description)

Reroof for Stone Elementary
Crossville, TN

The Owner and Architect agree as follows.

ADDITIONS AND DELETIONS:
The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed. A vertical line in the left margin of this document indicates where the author has added necessary information and where the author has added to or deleted from the original AIA text.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

TABLE OF ARTICLES

ARTICLE 1 INITIAL INFORMATION

§ 1.1 This Agreement is based on the Initial Information set forth below:
(State below details of the Project's site and program, Owner's contractors and consultants, Architect's consultants, Owner's budget for the Cost of the Work, and other information relevant to the Project.)

The scope of the project will consist of reroofing Stone Elementary School.

§ 1.2 The Owner and Architect may rely on the Initial Information. Both parties, however, recognize that such information may materially change and, in that event, the Owner and the Architect shall appropriately adjust the schedule, the Architect's services and the Architect's compensation. The Owner shall adjust the Owner's budget for the Cost of the Work and the Owner's anticipated design and construction milestones, as necessary, to accommodate material changes in the Initial Information.

§ 1.3 The parties shall agree upon protocols governing the transmission and use of Instruments of Service or any other information or documentation in digital form. The parties will use AIA Document E203™–2013, Building Information Modeling and Digital Data Exhibit, to establish the protocols for the development, use, transmission, and exchange of digital data.

§ 1.3.1 Any use of, or reliance on, all or a portion of a building information model without agreement to protocols governing the use of, and reliance on, the information contained in the model and without having those protocols set forth in AIA Document E203™–2013, Building Information Modeling and Digital Data Exhibit, and the requisite AIA Document G202™–2013, Project Building Information Modeling Protocol Form, shall be at the using or relying party's sole risk and without liability to the other party and its contractors or consultants, the authors of, or contributors to, the building information model, and each of their agents and employees.

ARTICLE 2 ARCHITECT'S RESPONSIBILITIES

§ 2.1 The Architect shall provide the professional services set forth in this Agreement consistent with the professional skill and care ordinarily provided by architects practicing in the same or similar locality under the same

or similar circumstances. The Architect shall perform its services as expeditiously as is consistent with such professional skill and care and the orderly progress of the Project.

§ 2.2 The Architect shall maintain the following insurance until termination of this Agreement. If any of the requirements set forth below are in addition to the types and limits the Architect normally maintains, the Owner shall pay the Architect as set forth in Section 11.8:
(Identify types and limits of insurance coverage, and other insurance requirements applicable to the Agreement, if any.)

.1 General Liability

$1,000,000.00

.2 Automobile Liability

$1,000,000.00

.3 Workers' Compensation

Yes

.4 Professional Liability

$1,000,000.00

ARTICLE 3 SCOPE OF ARCHITECT'S BASIC SERVICES

§ 3.1 The Architect's Basic Services consist of those described in this Article 3 and include usual and customary structural, mechanical, and electrical engineering services. Services not set forth in this Article 3 are Supplemental or Additional Services.

§ 3.1.1 The Architect shall coordinate its services with those services provided by the Owner and the Owner's consultants. The Architect shall be entitled to rely on (1) the accuracy and completeness of the services and information furnished by the Owner and (2) the Owner's approvals. The Architect shall provide prompt written notice to the Owner if the Architect becomes aware of any error, omission, or inconsistency in such services or information.

§ 3.1.2 As soon as practicable after the date of this Agreement, the Architect shall submit for the Owner's approval a schedule for the performance of the Architect's services. Once approved by the Owner, time limits established by the schedule shall not, except for reasonable cause, be exceeded by the Architect or Owner. With the Owner's approval, the Architect shall adjust the schedule, if necessary, as the Project proceeds until the commencement of construction.

§ 3.1.3 The Architect shall assist the Owner in connection with the Owner's responsibility for filing documents required for the approval of governmental authorities having jurisdiction over the Project.

§ 3.2 Design Phase Services

§ 3.2.1 The Architect shall review the program and other information furnished by the Owner, and shall review laws, codes, and regulations applicable to the Architect's services.

§ 3.2.2 The Architect shall discuss with the Owner the Owner's program, schedule, budget for the Cost of the Work, Project site, and alternative approaches to design and construction of the Project. The Architect shall reach an understanding with the Owner regarding the Project requirements.

§ 3.2.3 The Architect shall consider the relative value of alternative materials, building systems and equipment, together with other considerations based on program, aesthetics, and any sustainable objectives, in developing a design for the Project that is consistent with the Owner's schedule and budget for the Cost of the Work.

§ 3.2.4 Based on the Project requirements, the Architect shall prepare Design Documents for the Owner's approval consisting of drawings and other documents appropriate for the Project and the Architect shall prepare and submit to the Owner an estimate of the Cost of the Work prepared in accordance with Section 6.3.

§ 3.2.5 The Architect shall submit the Design Documents to the Owner, and request the Owner's approval.

§ 3.3 Construction Documents Phase Services

§ 3.3.1 Based on the Owner's approval of the Design Documents, the Architect shall prepare for the Owner's approval Construction Documents consisting of Drawings and Specifications setting forth in detail the requirements for the construction of the Work. The Owner and Architect acknowledge that in order to construct the Work the Contractor will provide additional information, including Shop Drawings, Product Data, Samples and other similar submittals, which the Architect shall review in accordance with Section 3.4.4.

§ 3.3.2 The Architect shall incorporate the design requirements of governmental authorities having jurisdiction over the Project into the Construction Documents.

§ 3.3.3 The Architect shall submit the Construction Documents to the Owner, update the estimate for the Cost of the Work and advise the Owner of any adjustments to the estimate of the Cost of the Work, take any action required under Section 6.5, and request the Owner's approval.

§ 3.3.4 The Architect, following the Owner's approval of the Construction Documents and of the latest estimate of the Cost of the Work, shall assist the Owner in obtaining bids or proposals and awarding and preparing contracts for construction.

§ 3.4 Construction Phase Services

§ 3.4.1 General

§ 3.4.1.1 The Architect shall provide administration of the Contract between the Owner and the Contractor as set forth below and in AIA Document A104™–2017, Standard Abbreviated Form of Agreement Between Owner and Contractor. If the Owner and Contractor modify AIA Document A104–2017, those modifications shall not affect the Architect's services under this Agreement unless the Owner and the Architect amend this Agreement.

§ 3.4.1.2 The Architect shall advise and consult with the Owner during the Construction Phase Services. The Architect shall have authority to act on behalf of the Owner only to the extent provided in this Agreement. The Architect shall not have control over, charge of, or responsibility for the construction means, methods, techniques, sequences or procedures, or for safety precautions and programs in connection with the Work, nor shall the Architect be responsible for the Contractor's failure to perform the Work in accordance with the requirements of the Contract Documents. The Architect shall be responsible for the Architect's negligent acts or omissions, but shall not have control over or charge of and shall not be responsible for, acts or omissions of the Contractor or of any other persons or entities performing portions of the Work.

§ 3.4.1.3 Subject to Section 4.2, the Architect's responsibility to provide Construction Phase Services commences with the award of the Contract for Construction and terminates on the date the Architect issues the final Certificate for Payment.

§ 3.4.2 Evaluations of the Work

§ 3.4.2.1 The Architect shall visit the site at intervals appropriate to the stage of construction, or as otherwise required in Section 4.2.2, to become generally familiar with the progress and quality of the portion of the Work completed, and to determine, in general, if the Work observed is being performed in a manner indicating that the Work, when fully completed, will be in accordance with the Contract Documents. However, the Architect shall not be required to make exhaustive or continuous on-site inspections to check the quality or quantity of the Work. On the basis of the site visits, the Architect shall keep the Owner reasonably informed about the progress and quality of the portion of the Work completed, and promptly report to the Owner (1) known deviations from the Contract Documents, (2) known deviations from the most recent construction schedule submitted by the Contractor, and (3) defects and deficiencies observed in the Work.

§ 3.4.2.2 The Architect has the authority to reject Work that does not conform to the Contract Documents and has the authority to require inspection or testing of the Work.

§ 3.4.2.3 The Architect shall interpret and decide matters concerning performance under, and requirements of, the Contract Documents on written request of either the Owner or Contractor. The Architect's response to such requests shall be made in writing within any time limits agreed upon or otherwise with reasonable promptness.

§ 3.4.2.4 When making such interpretations and decisions, the Architect shall endeavor to secure faithful performance by both Owner and Contractor, shall not show partiality to either, and shall not be liable for results of interpretations or decisions rendered in good faith.

§ 3.4.2.5 The Architect shall render initial decisions on Claims between the Owner and Contractor as provided in the Contract Documents.

§ 3.4.3 Certificates for Payment to Contractor

§ 3.4.3.1 The Architect shall review and certify the amounts due the Contractor and shall issue certificates in such amounts. The Architect's certification for payment shall constitute a representation to the Owner, based on the Architect's evaluation of the Work as provided in Section 3.4.2 and on the data comprising the Contractor's Application for Payment, that, to the best of the Architect's knowledge, information and belief, the Work has progressed to the point indicated, the quality of the Work is in accordance with the Contract Documents, and that the Contractor is entitled to payment in the amount certified.

§ 3.4.3.2 The issuance of a Certificate for Payment shall not be a representation that the Architect has (1) made exhaustive or continuous on-site inspections to check the quality or quantity of the Work, (2) reviewed construction means, methods, techniques, sequences or procedures, (3) reviewed copies of requisitions received from Subcontractors and suppliers and other data requested by the Owner to substantiate the Contractor's right to payment, or (4) ascertained how or for what purpose the Contractor has used money previously paid on account of the Contract Sum.

§ 3.4.4 Submittals

§ 3.4.4.1 The Architect shall review and approve, or take other appropriate action, upon the Contractor's submittals such as Shop Drawings, Product Data and Samples, but only for the limited purpose of checking for conformance with information given and the design concept expressed in the Contract Documents. Review of such submittals is not for the purpose of determining the accuracy and completeness of other information such as dimensions, quantities, and installation or performance of equipment or systems, which are the Contractor's responsibility. The Architect's review shall not constitute approval of safety precautions or any construction means, methods, techniques, sequences or procedures.

§ 3.4.4.2 If the Contract Documents specifically require the Contractor to provide professional design services or certifications by a design professional related to systems, materials or equipment, the Architect shall specify the appropriate performance and design criteria that such services must satisfy. The Architect shall review and take appropriate action on Shop Drawings and other submittals related to the Work designed or certified by the Contractor's design professional, provided the submittals bear such professional's seal and signature when submitted to the Architect. The review shall be for the limited purpose of checking for conformance with information given and the design concept expressed in the Contract Documents. The Architect shall be entitled to rely upon, and shall not be responsible for, the adequacy and accuracy of the services, certifications, and approvals performed or provided by such design professionals.

§ 3.4.4.3 The Architect shall review and respond to written requests for information about the Contract Documents. The Architect's response to such requests shall be made in writing within any time limits agreed upon, or otherwise with reasonable promptness.

§ 3.4.5 Changes in the Work

The Architect may order minor changes in the Work that are consistent with the intent of the Contract Documents and do not involve an adjustment in the Contract Sum or an extension of the Contract Time. Subject to Section 4.2.3, the Architect shall prepare Change Orders and Construction Change Directives for the Owner's approval and execution in accordance with the Contract Documents.

§ 3.4.6 Project Completion

The Architect shall conduct inspections to determine the date or dates of Substantial Completion and the date of final completion; issue Certificates of Substantial Completion; forward to the Owner, for the Owner's review and records, written warranties and related documents required by the Contract Documents and received from the Contractor; and issue a final Certificate for Payment based upon a final inspection indicating that, to the best of the Architect's knowledge, information, and belief, the Work complies with the requirements of the Contract Documents.

ARTICLE 4 SUPPLEMENTAL AND ADDITIONAL SERVICES

§ 4.1 Supplemental Services are not included in Basic Services but may be required for the Project. The Architect shall provide the Supplemental Services indicated below, and the Owner shall compensate the Architect as provided in Section 11.2. Supplemental Services may include programming, site evaluation and planning, environmental studies, civil engineering, landscape design, telecommunications/data, security, measured drawings of existing conditions, coordination of separate contractors or independent consultants, detailed cost estimates, on-site project representation beyond requirements of Section 4.2.2, value analysis, interior architectural design, tenant related services, preparation of record drawings, commissioning, sustainable project services, and any other services not otherwise included in this Agreement.
(Identify below the Supplemental Services that the Architect is required to provide and insert a description of each Supplemental Service, if not further described in an exhibit attached to this document.)

N/A

§ 4.2 The Architect may provide Additional Services after execution of this Agreement without invalidating the Agreement. Upon recognizing the need to perform Additional Services, the Architect shall notify the Owner. The Architect shall not provide the Additional Services until the Architect receives the Owner's written authorization. Except for services required due to the fault of the Architect, any Additional Services provided in accordance with this Section 4.2 shall entitle the Architect to compensation pursuant to Section 11.3.

§ 4.2.1 The Architect shall provide services necessitated by a change in the Initial Information, changes in previous instructions or approvals given by the Owner, or a material change in the Project including size; quality; complexity; the Owner's schedule or budget for Cost of the Work; or procurement or delivery method as an Additional Service.

§ 4.2.2 The Architect has included in Basic Services visits to the site as needed by the Architect during construction. The Architect shall conduct site visits in excess of that amount as an Additional Service.

(Paragraph Deleted)

§ 4.2.3 The Architect shall, as an Additional Service, provide services made necessary by a Contractor's proposed change in the Work. The Architect shall prepare revisions to the Architect's Instruments of Service necessitated by Change Orders and Construction Change Directives as an Additional Service.

§ 4.2.4 If the services covered by this Agreement have not been completed within Thirty-Six (36) months of the date of this Agreement, through no fault of the Architect, extension of the Architect's services beyond that time shall be compensated as Additional Services.

ARTICLE 5 OWNER'S RESPONSIBILITIES

§ 5.1 Unless otherwise provided for under this Agreement, the Owner shall provide information in a timely manner regarding requirements for and limitations on the Project, including a written program which shall set forth the Owner's objectives, schedule, constraints and criteria, including space requirements and relationships, flexibility, expandability, special equipment, systems and site requirements.

§ 5.2 The Owner shall establish the Owner's budget for the Project, including (1) the budget for the Cost of the Work as defined in Section 6.1; (2) the Owner's other costs; and, (3) reasonable contingencies related to all of these costs. The Owner shall update the Owner's budget for the Project as necessary throughout the duration of the Project until final completion. If the Owner significantly increases or decreases the Owner's budget for the Cost of the Work, the

Owner shall notify the Architect. The Owner and the Architect shall thereafter agree to a corresponding change in the Project's scope and quality.

§ 5.3 The Owner shall furnish surveys to describe physical characteristics, legal limitations and utility locations for the site of the Project; a written legal description of the site; and services of geotechnical engineers or other consultants, when the Architect requests such services and demonstrates that they are reasonably required by the scope of the Project.

§ 5.4 The Owner shall coordinate the services of its own consultants with those services provided by the Architect. Upon the Architect's request, the Owner shall furnish copies of the scope of services in the contracts between the Owner and the Owner's consultants. The Owner shall require that its consultants and contractors maintain insurance, including professional liability insurance, as appropriate to the services or work provided.

§ 5.5 The Owner shall furnish tests, inspections and reports required by law or the Contract Documents, such as structural, mechanical, and chemical tests; tests for air and water pollution; and tests for hazardous materials.

§ 5.6 The Owner shall furnish all legal, insurance and accounting services, including auditing services, that may be reasonably necessary at any time for the Project to meet the Owner's needs and interests.

§ 5.7 The Owner shall provide prompt written notice to the Architect if the Owner becomes aware of any fault or defect in the Project, including errors, omissions or inconsistencies in the Architect's Instruments of Service.

§ 5.8 The Owner shall endeavor to communicate with the Contractor through the Architect about matters arising out of or relating to the Contract Documents.

§ 5.9 The Owner shall provide the Architect access to the Project site prior to commencement of the Work and shall obligate the Contractor to provide the Architect access to the Work wherever it is in preparation or progress.

§ 5.10 Within 15 days after receipt of a written request from the Architect, the Owner shall furnish the requested information as necessary and relevant for the Architect to evaluate, give notice of, or enforce lien rights.

ARTICLE 6 COST OF THE WORK

§ 6.1 For purposes of this Agreement, the Cost of the Work shall be the total cost to the Owner to construct all elements of the Project designed or specified by the Architect and shall include contractors' general conditions costs, overhead and profit. The Cost of the Work also includes the reasonable value of labor, materials, and equipment, donated to, or otherwise furnished by, the Owner. The Cost of the Work does not include the compensation of the Architect; the costs of the land, rights-of-way, financing, or contingencies for changes in the Work; or other costs that are the responsibility of the Owner.

§ 6.2 The Owner's budget for the Cost of the Work is provided in Initial Information, and shall be adjusted throughout the Project as required under Sections 5.2, 6.4 and 6.5. Evaluations of the Owner's budget for the Cost of the Work, and the preliminary estimate of the Cost of the Work and updated estimates of the Cost of the Work prepared by the Architect, represent the Architect's judgment as a design professional. It is recognized, however, that neither the Architect nor the Owner has control over the cost of labor, materials or equipment; the Contractor's methods of determining bid prices; or competitive bidding, market or negotiating conditions. Accordingly, the Architect cannot and does not warrant or represent that bids or negotiated prices will not vary from the Owner's budget for the Cost of the Work, or from any estimate of the Cost of the Work, or evaluation, prepared or agreed to by the Architect.

§ 6.3 In preparing estimates of the Cost of Work, the Architect shall be permitted to include contingencies for design, bidding and price escalation; to determine what materials, equipment, component systems and types of construction are to be included in the Contract Documents; to recommend reasonable adjustments in the program and scope of the Project; and to include design alternates as may be necessary to adjust the estimated Cost of the Work to meet the Owner's budget. The Architect's estimate of the Cost of the Work shall be based on current area, volume or similar conceptual estimating techniques. If the Owner requires a detailed estimate of the Cost of the Work, the Architect shall provide such an estimate, if identified as the Architect's responsibility in Section 4.1, as a Supplemental Service.

§ 6.4 If, through no fault of the Architect, construction procurement activities have not commenced within 90 days after the Architect submits the Construction Documents to the Owner the Owner's budget for the Cost of the Work shall be adjusted to reflect changes in the general level of prices in the applicable construction market.

§ 6.5 If at any time the Architect's estimate of the Cost of the Work exceeds the Owner's budget for the Cost of the Work, the Architect shall make appropriate recommendations to the Owner to adjust the Project's size, quality or budget for the Cost of the Work, and the Owner shall cooperate with the Architect in making such adjustments.

§ 6.6 If the Owner's current budget for the Cost of the Work at the conclusion of the Construction Documents Phase Services is exceeded by the lowest bona fide bid or negotiated proposal, the Owner shall

- **.1** give written approval of an increase in the budget for the Cost of the Work;
- **.2** authorize rebidding or renegotiating of the Project within a reasonable time;
- **.3** terminate in accordance with Section 9.5;
- **.4** in consultation with the Architect, revise the Project program, scope, or quality as required to reduce the Cost of the Work; or
- **.5** implement any other mutually acceptable alternative.

§ 6.7 If the Owner chooses to proceed under Section 6.6.4, the Architect shall modify the Construction Documents as necessary to comply with the Owner's budget for the Cost of the Work at the conclusion of the Construction Documents Phase Services, or the budget as adjusted under Section 6.6.1. If the Owner requires the Architect to modify the Construction Documents because the lowest bona fide bid or negotiated proposal exceeds the Owner's budget for the Cost of the Work due to market conditions the Architect could not reasonably anticipate, the Owner shall compensate the Architect for the modifications as an Additional Service pursuant to Section 11.3; otherwise the Architect's services shall be without additional compensation. In any event, the Architect's modification of the Construction Documents shall be the limit of the Architect's responsibility under this Article 6.

ARTICLE 7 COPYRIGHTS AND LICENSES

§ 7.1 The Architect and the Owner warrant that in transmitting Instruments of Service, or any other information, the transmitting party is the copyright owner of such information or has permission from the copyright owner to transmit such information for its use on the Project.

§ 7.2 The Architect and the Architect's consultants shall be deemed the authors and owners of their respective Instruments of Service, including the Drawings and Specifications, and shall retain all common law, statutory and other reserved rights, including copyrights. Submission or distribution of Instruments of Service to meet official regulatory requirements or for similar purposes in connection with the Project is not to be construed as publication in derogation of the reserved rights of the Architect and the Architect's consultants.

§ 7.3 The Architect grants to the Owner a nonexclusive license to use the Architect's Instruments of Service solely and exclusively for purposes of constructing, using, maintaining, altering and adding to the Project, provided that the Owner substantially performs its obligations under this Agreement, including prompt payment of all sums when due pursuant to Article 9 and Article 11. The Architect shall obtain similar nonexclusive licenses from the Architect's consultants consistent with this Agreement. The license granted under this section permits the Owner to authorize the Contractor, Subcontractors, Sub-subcontractors, and suppliers, as well as the Owner's consultants and separate contractors, to reproduce applicable portions of the Instruments of Service, subject to any protocols established pursuant to Section 1.3, solely and exclusively for use in performing services or construction for the Project. If the Architect rightfully terminates this Agreement for cause as provided in Section 9.4, the license granted in this Section 7.3 shall terminate.

§ 7.3.1 In the event the Owner uses the Instruments of Service without retaining the authors of the Instruments of Service, the Owner releases the Architect and Architect's consultant(s) from all claims and causes of action arising from such uses. The Owner, to the extent permitted by law, further agrees to indemnify and hold harmless the Architect and its consultants from all costs and expenses, including the cost of defense, related to claims and causes of action asserted by any third person or entity to the extent such costs and expenses arise from the Owner's use of the Instruments of Service under this Section 7.3.1. The terms of this Section 7.3.1 shall not apply if the Owner rightfully terminates this Agreement for cause under Section 9.4.

§ 7.4 Except for the licenses granted in this Article 7, no other license or right shall be deemed granted or implied under this Agreement. The Owner shall not assign, delegate, sublicense, pledge or otherwise transfer any license granted herein to another party without the prior written agreement of the Architect. Any unauthorized use of the Instruments of Service shall be at the Owner's sole risk and without liability to the Architect and the Architect's consultants.

§ 7.5 Except as otherwise stated in Section 7.3, the provisions of this Article 7 shall survive the termination of this Agreement.

ARTICLE 8 CLAIMS AND DISPUTES

§ 8.1 General

§ 8.1.1 The Owner and Architect shall commence all claims and causes of action against the other and arising out of or related to this Agreement, whether in contract, tort, or otherwise, in accordance with the requirements of the binding dispute resolution method selected in this Agreement and within the period specified by applicable law, but in any case not more than 10 years after the date of Substantial Completion of the Work. The Owner and Architect waive all claims and causes of action not commenced in accordance with this Section 8.1.1.

§ 8.1.2 To the extent damages are covered by property insurance, the Owner and Architect waive all rights against each other and against the contractors, consultants, agents, and employees of the other, for damages, except such rights as they may have to the proceeds of such insurance as set forth in AIA Document A104–2017, Standard Abbreviated Form of Agreement Between Owner and Contractor. The Owner or the Architect, as appropriate, shall require of the contractors, consultants, agents, and employees of any of them, similar waivers in favor of the other parties enumerated herein.

§ 8.1.3 The Architect and Owner waive consequential damages for claims, disputes or other matters in question, arising out of or relating to this Agreement. This mutual waiver is applicable, without limitation, to all consequential damages due to either party's termination of this Agreement, except as specifically provided in Section 9.6

§ 8.2 Mediation

§ 8.2.1 Any claim, dispute or other matter in question arising out of or related to this Agreement shall be subject to mediation as a condition precedent to binding dispute resolution. If such matter relates to or is the subject of a lien arising out of the Architect's services, the Architect may proceed in accordance with applicable law to comply with the lien notice or filing deadlines prior to resolution of the matter by mediation or by binding dispute resolution.

§ 8.2.2 Mediation, unless the parties mutually agree otherwise, shall be administered by the American Arbitration Association in accordance with its Construction Industry Mediation Procedures in effect on the date of this Agreement. The parties shall share the mediator's fee and any filing fees equally. The mediation shall be held in the place where the Project is located, unless another location is mutually agreed upon. Agreements reached in mediation shall be enforceable as settlement agreements in any court having jurisdiction thereof.

§ 8.2.3 If the parties do not resolve a dispute through mediation pursuant to this Section 8.2, the method of binding dispute resolution shall be the following:
(Check the appropriate box.)

[ ] Arbitration pursuant to Section 8.3 of this Agreement

[X] Litigation in a court of competent jurisdiction

[ ] Other: (Specify)

If the Owner and Architect do not select a method of binding dispute resolution, or do not subsequently agree in writing to a binding dispute resolution method other than litigation, the dispute will be resolved in a court of competent jurisdiction.

(Paragraphs Deleted)

§ 8.3.3 The award rendered by the arbitrator(s) shall be final, and judgment may be entered upon it in accordance with applicable law in any court having jurisdiction thereof.

§ 8.3.4 Consolidation or Joinder

§ 8.3.4.1 Either party, at its sole discretion, may consolidate an arbitration conducted under this Agreement with any other arbitration to which it is a party provided that (1) the arbitration agreement governing the other arbitration permits consolidation; (2) the arbitrations to be consolidated substantially involve common questions of law or fact; and (3) the arbitrations employ materially similar procedural rules and methods for selecting arbitrator(s).

§ 8.3.4.2 Either party, at its sole discretion, may include by joinder persons or entities substantially involved in a common question of law or fact whose presence is required if complete relief is to be accorded in arbitration, provided that the party sought to be joined consents in writing to such joinder. Consent to arbitration involving an additional person or entity shall not constitute consent to arbitration of any claim, dispute or other matter in question not described in the written consent.

§ 8.3.4.3 The Owner and Architect grant to any person or entity made a party to an arbitration conducted under this Section 8.3, whether by joinder or consolidation, the same rights of joinder and consolidation as the Owner and Architect under this Agreement.

§ 8.4 The provisions of this Article 8 shall survive the termination of this Agreement.

ARTICLE 9 TERMINATION OR SUSPENSION

§ 9.1 If the Owner fails to make payments to the Architect in accordance with this Agreement, such failure shall be considered substantial nonperformance and cause for termination or, at the Architect's option, cause for suspension of performance of services under this Agreement. If the Architect elects to suspend services, the Architect shall give seven days' written notice to the Owner before suspending services. In the event of a suspension of services, the Architect shall have no liability to the Owner for delay or damage caused the Owner because of such suspension of services. Before resuming services, the Owner shall pay the Architect all sums due prior to suspension and any expenses incurred in the interruption and resumption of the Architect's services. The Architect's fees for the remaining services and the time schedules shall be equitably adjusted.

§ 9.2 If the Owner suspends the Project, the Architect shall be compensated for services performed prior to notice of such suspension. When the Project is resumed, the Architect shall be compensated for expenses incurred in the interruption and resumption of the Architect's services. The Architect's fees for the remaining services and the time schedules shall be equitably adjusted.

§ 9.3 If the Owner suspends the Project for more than 90 cumulative days for reasons other than the fault of the Architect, the Architect may terminate this Agreement by giving not less than seven days' written notice.

§ 9.4 Either party may terminate this Agreement upon not less than seven days' written notice should the other party fail substantially to perform in accordance with the terms of this Agreement through no fault of the party initiating the termination.

§ 9.5 The Owner may terminate this Agreement upon not less than seven days' written notice to the Architect for the Owner's convenience and without cause.

§ 9.6 In the event of termination not the fault of the Architect, the Architect shall be compensated for services performed prior to termination, Reimbursable Expenses incurred, and all costs attributable to termination, including the costs attributable to the Architect's termination of consultant agreements.

§ 9.7 In addition to any amounts paid under Section 9.6, if the Owner terminates this Agreement for its convenience pursuant to Section 9.5, or the Architect terminates this Agreement pursuant to Section 9.3, the Owner shall pay to the Architect the following fees:

(Set forth below the amount of any termination or licensing fee, or the method for determining any termination or licensing fee.)

.1 Termination Fee:

Remaining costs and expenses of current phase of the work

.2 Licensing Fee if the Owner intends to continue using the Architect's Instruments of Service:

To be negotiated

§ 9.8 Except as otherwise expressly provided herein, this Agreement shall terminate one year from the date of Substantial Completion.

ARTICLE 10 MISCELLANEOUS PROVISIONS

§ 10.1 This Agreement shall be governed by the law of the place where the Project is located excluding that jurisdiction's choice of law rules. If the parties have selected arbitration as the method of binding dispute resolution, the Federal Arbitration Act shall govern Section 8.3.

§ 10.2 Terms in this Agreement shall have the same meaning as those in AIA Document A104–2017, Standard Abbreviated Form of Agreement Between Owner and Contractor.

§ 10.3 The Owner and Architect, respectively, bind themselves, their agents, successors, assigns and legal representatives to this Agreement. Neither the Owner nor the Architect shall assign this Agreement without the written consent of the other, except that the Owner may assign this Agreement to a lender providing financing for the Project if the lender agrees to assume the Owner's rights and obligations under this Agreement, including any payments due to the Architect by the Owner prior to the assignment.

§ 10.4 If the Owner requests the Architect to execute certificates or consents, the proposed language of such certificates or consents shall be submitted to the Architect for review at least 14 days prior to the requested dates of execution. The Architect shall not be required to execute certificates or consents that would require knowledge, services or responsibilities beyond the scope of this Agreement.

§ 10.5 Nothing contained in this Agreement shall create a contractual relationship with, or a cause of action in favor of, a third party against either the Owner or Architect.

§ 10.6 The Architect shall have no responsibility for the discovery, presence, handling, removal or disposal of, or exposure of persons to, hazardous materials or toxic substances in any form at the Project site.

§ 10.7 The Architect shall have the right to include photographic or artistic representations of the design of the Project among the Architect's promotional and professional materials. However, the Architect's materials shall not include information the Owner has identified in writing as confidential or proprietary. The Owner shall provide professional credit for the Architect in the Owner's promotional materials for the Project. This Section 10.7 shall survive the termination of this Agreement unless the Owner terminates this Agreement for cause pursuant to Section 9.4.

§ 10.8 The invalidity of any provision of the Agreement shall not invalidate the Agreement or its remaining provisions. If it is determined that any provision of the Agreement violates any law, or is otherwise invalid or unenforceable, then that provision shall be revised to the extent necessary to make that provision legal and enforceable. In such case the Agreement shall be construed, to the fullest extent permitted by law, to give effect to the parties' intentions and purposes in executing the Agreement.

ARTICLE 11 COMPENSATION

§ 11.1 For the Architect's Basic Services described under Article 3, the Owner shall compensate the Architect as follows:

(Paragraph Deleted)

.1 Percentage Basis
(Insert percentage value)

Five (5) % of the Owner's budget for the Cost of the Work, as calculated in accordance with Section 11.6.

(Paragraph Deleted)

§ 11.2 For Supplemental Services identified in Section 4.1, the Owner shall compensate the Architect as follows:
(Insert amount of, or basis for, compensation. If necessary, list specific services to which particular methods of compensation apply.)

N/A

§ 11.3 For Additional Services that may arise during the course of the Project, including those under Section 4.2, the Owner shall compensate the Architect as follows:
(Insert amount of, or basis for, compensation.)

N/A

§ 11.4 Compensation for Supplemental and Additional Services of the Architect's consultants when not included in Section 11.2 or 11.3, shall be the amount invoiced to the Architect plus Twenty percent (20 %), or as follows:

§ 11.5 Where compensation for Basic Services is based on a stipulated sum or percentage of the Cost of the Work, the compensation for each phase of services shall be as follows:

Design Phase	Twenty-Five	percent (	25	%)
Construction Documents Phase	Fifty	percent (	50	%)
Construction Phase	Twenty-Five	percent (	25	%)
Total Basic Compensation	one hundred	percent (	100	%)

§ 11.6 When compensation identified in Section 11.1 is on a percentage basis, progress payments for each phase of Basic Services shall be calculated by multiplying the percentages identified in this Article by the Owner's most recent budget for the Cost of the Work. Compensation paid in previous progress payments shall not be adjusted based on subsequent updates to the Owner's budget for the Cost of the Work.

§ 11.6.1 When compensation is on a percentage basis and any portions of the Project are deleted or otherwise not constructed, compensation for those portions of the Project shall be payable to the extent services are performed on those portions. The Architect shall be entitled to compensation in accordance with this Agreement for all services performed whether or not the Construction Phase is commenced.

§ 11.7 The hourly billing rates for services of the Architect and the Architect's consultants, if any, are set forth below. The rates shall be adjusted in accordance with the Architect's and Architect's consultants' normal review practices.
(If applicable, attach an exhibit of hourly billing rates or insert them below.)

N/A

Employee or Category	Rate

§ 11.8 Compensation for Reimbursable Expenses

§ 11.8.1 Reimbursable Expenses are in addition to compensation for Basic, Supplemental, and Additional Services and include expenses incurred by the Architect and the Architect's consultants directly related to the Project, as follows:

(Paragraphs Deleted)

.3 Permitting and other fees required by authorities having jurisdiction over the Project;
.4 Printing, reproductions, plots, and standard form documents for construction

(Paragraphs Deleted)

.9 All taxes levied on professional services and on reimbursable expenses;

(Paragraphs Deleted)

§ 11.8.2 For Reimbursable Expenses the compensation shall be the expenses incurred by the Architect and the Architect's consultants plus zero percent (0 %) of the expenses incurred.

§ 11.9 Payments to the Architect

§ 11.9.1 Initial Payment

An initial payment of Zero Dollars ($ 0) shall be made upon execution of this Agreement and is the minimum payment under this Agreement. It shall be credited to the Owner's account in the final invoice.

§ 11.9.2 Progress Payments

§ 11.9.2.1 Unless otherwise agreed, payments for services shall be made monthly in proportion to services performed. Payments are due and payable upon presentation of the Architect's invoice. Amounts unpaid ( ) days after the invoice date shall bear interest at the rate entered below, or in the absence thereof at the legal rate prevailing from time to time at the principal place of business of the Architect.
(Insert rate of monthly or annual interest agreed upon.)

1 % Monthly

§ 11.9.2.2 The Owner shall not withhold amounts from the Architect's compensation to impose a penalty or liquidated damages on the Architect, or to offset sums requested by or paid to contractors for the cost of changes in the Work unless the Architect agrees or has been found liable for the amounts in a binding dispute resolution proceeding.

§ 11.9.2.3 Records of Reimbursable Expenses, expenses pertaining to Additional Services, and services performed on the basis of hourly rates shall be available to the Owner at mutually convenient times.

ARTICLE 12 SPECIAL TERMS AND CONDITIONS

Special terms and conditions that modify this Agreement are as follows:
(Include other terms and conditions applicable to this Agreement.)

N/A

ARTICLE 13 SCOPE OF THE AGREEMENT

§ 13.1 This Agreement represents the entire and integrated agreement between the Owner and the Architect and supersedes all prior negotiations, representations or agreements, either written or oral. This Agreement may be amended only by written instrument signed by both the Owner and Architect.

§ 13.2 This Agreement is comprised of the following documents identified below:

.1 AIA Document B104™–2017, Standard Abbreviated Form of Agreement Between Owner and Architect

(Paragraph Deleted)

(Paragraphs Deleted)

This Agreement entered into as of the day and year first written above.

OWNER (Signature)	**ARCHITECT** (Signature)
Jim Inman , Board Chairman	Kim Allen Chamberlin, President
(Printed name and title)	*(Printed name, title, and license number, if required)*

Upland Design Group

P.O. Box 1026
Crossville, TN 38557
Ph. 931-484-7541
www.uplanddesigngroup.com

August 15, 2022

Contract Amendment to B105-2017 Agreement between Owner and Architect dated January 14, 2022.

Added Work Scope:

Upland Design Group will provide full Architectural Services for Phases 2 and 3 of the Electrical Upgrades at North Cumberland Elementary School.

Fee: $22,500 Lump Sum

Owner	Architect
_____	_____
Jim Inman, Board Chairman	Kim Allen Chamberlin, President

P.O. Box 1026
Crossville, TN 38557
Ph. 931 484-7541
www.uplanddesigngroup.com

Project: Electrical Upgrades at
North Cumberland Elementary School

Project No.: 2121

To: Cumberland County BOE
Crossville, TN

Date: 8/16/22

Attn:

CC:

Fax:

CC:

Please find the attached as follows:

Copies	Description
2	B105 – 2017 Contract (Owner / Architect) and Contract Amendment

Message:

Hello,

Please sign all both copies of the contract. Return one (1) to us at Upland Design Group and retain one (1) for your records.

Thank You,
Bonnie Threet
(Administrative Assistant)

2121

AIA® Document B105™ – 2017

Standard Short Form of Agreement Between Owner and Architect

AGREEMENT made as of the Fourteenth day of January in the year Two Thousand Twenty-Two
(In words, indicate day, month and year.)

BETWEEN the Owner:
(Name, legal status, address and other information)

Cumberland County Schools
368 Fourth Street
Crossville, TN 38555
Telephone Number: (931) 484-6135
Fax Number: (931) 484-6491

and the Architect:
(Name, legal status, address and other information)

Upland Design Group, Inc.
P. O. Box 1026
362 Industrial Blvd. (38555)
Crossville, TN 38557
Telephone Number: 931-484-7541
Fax Number: 931-484-2351

for the following Project:
(Name, location and detailed description)

North Cumberland Elementary Electrical Upgrade
Crossville, TN

The Owner and Architect agree as follows.

ADDITIONS AND DELETIONS:
The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed. A vertical line in the left margin of this document indicates where the author has added necessary information and where the author has added to or deleted from the original AIA text.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

ARTICLE 1 ARCHITECT'S RESPONSIBILITIES

The Architect shall provide architectural services for the Project as described in this Agreement. The Architect shall perform its services consistent with the professional skill and care ordinarily provided by architects practicing in the same or similar locality under the same or similar circumstances. The Architect shall perform its services as expeditiously as is consistent with such professional skill and care and the orderly progress of the Project. The Architect shall assist the Owner in determining consulting services required for the Project. The Architect's services include the following consulting services, if any:

Provide construction documents for the replacement of the main electrical switchboard serving the existing school building and five other existing panels in the building that contain inline fused breakers. New service entrance feeder conductors to the main electrical switchboard will also be included as part of the work scope.

During the Design Phase, the Architect shall review the Owner's scope of work, budget and schedule and reach an understanding with the Owner of the Project requirements. Based on the approved Project requirements, the Architect shall develop a design, which shall be set forth in drawings and other documents appropriate for the Project. Upon the Owner's approval of the design, the Architect shall prepare Construction Documents indicating requirements for construction of the Project and shall coordinate its services with any consulting services the Owner provides. The Architect shall assist the Owner in filing documents required for the approval of governmental authorities, in obtaining bids or proposals, and in awarding contracts for construction.

During the Construction Phase, the Architect shall act as the Owner's representative and provide administration of the Contract between the Owner and Contractor. The extent of the Architect's authority and responsibility during construction is described in AIA Document A105™–2017, Standard Short Form of Agreement Between Owner and Contractor. If the Owner and Contractor modify AIA Document A105–2017, those modifications shall not affect the Architect's services under this Agreement, unless the Owner and Architect amend this Agreement.

ARTICLE 2 OWNER'S RESPONSIBILITIES

The Owner shall provide full information about the objectives, schedule, constraints and existing conditions of the Project, and shall establish a budget that includes reasonable contingencies and meets the Project requirements. The Owner shall provide decisions and furnish required information as expeditiously as necessary for the orderly progress of the Project. The Architect shall be entitled to rely on the accuracy and completeness of the Owner's information. The Owner shall furnish consulting services not provided by the Architect, but required for the Project, such as surveying, which shall include property boundaries, topography, utilities, and wetlands information; geotechnical engineering; and environmental testing services. The Owner shall employ a Contractor, experienced in the type of Project to be constructed, to perform the construction Work and to provide price information.

ARTICLE 3 USE OF DOCUMENTS

Drawings, specifications and other documents prepared by the Architect are the Architect's Instruments of Service, and are for the Owner's use solely with respect to constructing the Project. The Architect shall retain all common law, statutory and other reserved rights, including the copyright. Upon completion of the construction of the Project, provided that the Owner substantially performs its obligations under this Agreement, the Architect grants to the Owner a license to use the Architect's Instruments of Service as a reference for maintaining, altering and adding to the Project. The Owner agrees to indemnify the Architect from all costs and expenses related to claims arising from the Owner's use of the Instruments of Service without retaining the Architect. When transmitting copyright-protected information for use on the Project, the transmitting party represents that it is either the copyright owner of the information, or has permission from the copyright owner to transmit the information for its use on the Project.

ARTICLE 4 TERMINATION, SUSPENSION OR ABANDONMENT

In the event of termination, suspension or abandonment of the Project by the Owner, the Architect shall be compensated for services performed. The Owner's failure to make payments in accordance with this Agreement shall be considered substantial nonperformance and sufficient cause for the Architect to suspend or terminate services. Either the Architect or the Owner may terminate this Agreement after giving no less than seven days' written notice if the Project is suspended for more than 90 days, or if the other party substantially fails to perform in accordance with the terms of this Agreement. Except as otherwise expressly provided herein, this Agreement shall terminate one year from the date of Substantial Completion.

ARTICLE 5 MISCELLANEOUS PROVISIONS

This Agreement shall be governed by the law of the place where the Project is located. Terms in this Agreement shall have the same meaning as those in AIA Document A105–2017, Standard Short Form of Agreement Between Owner and Contractor. Neither party to this Agreement shall assign the contract as a whole without written consent of the other.

Nothing contained in this Agreement shall create a contractual relationship with, or a cause of action in favor of, a third party against either the Owner or the Architect.

The Architect shall have no responsibility for the discovery, presence, handling, removal or disposal of, or exposure of persons to, hazardous materials or toxic substances in any form at the Project site.

ARTICLE 6 PAYMENTS AND COMPENSATION TO THE ARCHITECT

The Architect's Compensation shall be:

Lump Sum $11,900.00

The Owner shall pay the Architect an initial payment of ($) as a minimum payment under this Agreement. The initial payment shall be credited to the final invoice.

The Owner shall reimburse the Architect for expenses incurred in the interest of the Project, plus percent (%).

Payments are due and payable upon receipt of the Architect's monthly invoice. Amounts unpaid ( ) days after the invoice date shall bear interest from the date payment is due at the rate of percent (%) , or in the absence thereof, at the legal rate prevailing at the principal place of business of the Architect.

At the request of the Owner, the Architect shall provide additional services not included in Article 1 for additional compensation. Such additional services may include, but not be limited to, providing or coordinating services of consultants not identified in Article 1; revisions due to changes in the Project scope, quality or budget, or due to Owner-requested changes in the approved design; evaluating changes in the Work and Contractors' requests for substitutions of materials or systems; providing services necessitated by the Contractor's failure to perform; and the extension of the Architect's Article 1 services beyond ( ) months of the date of this Agreement through no fault of the Architect.

ARTICLE 7 OTHER PROVISIONS

(Insert descriptions of other services and modifications to the terms of this Agreement.)

None

This Agreement entered into as of the day and year first written above.

OWNER (Signature)	**ARCHITECT** (Signature)
Jim Inman , Board Chairman	Kim Allen Chamberlin, President
(Printed name and title)	*(Printed name, title, and license number, if required)*

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare - Contract Support
Attention: Imaging Center
2300 W Plano Pkwy #C1E105
Plano, TX 75075-8427

(866) 574-6088

You can visit our website at www.UHCprovider.com for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT
UnitedHealthcare Community Plan

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of Tennessee, Inc., UnitedHealthcare Plan of the River Valley, Inc., and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 4. When this agreement refers to "you", it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Manual so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Manual), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements at www.UHCprovider.com as they become available and will make information available to you as to which products are supported by www.UHCprovider.com.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Manual.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Manual.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely

claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Manual). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available.

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in

response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicare and Medicaid Services (for example, HCPCS). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

We will give you 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce your overall reimbursement under this agreement, you may terminate this agreement by giving 60 days written notice to us, provided that the notice is given by you within 30 days after the notice of the fee schedule change.

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 3. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 3. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 4. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or are acquired by, merged with, or otherwise become affiliated with another provider of health care services that is already under contract with us or one of our affiliates to participate in a network of health care providers, this agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to those agreements.

If you decide to transfer some or all of your assets to another entity, and the result of the transfer would be that all or some of the services subject to this agreement would be rendered by the other entity rather than by you, you must first request that we approve an assignment of this agreement as it relates to those services and the other entity must agree to assume this agreement.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, this agreement has an initial term of three years, and it will automatically renew after the initial term, for renewal terms of one year each. Either you or we can terminate this agreement, effective at the end of the initial term or effective at the end of any renewal term, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427, or to the post office address you provided us. We both will treat termination notices as "received" on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).

- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") following the dispute procedures set out in our Administrative Manual. Disputes may include, but not be limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which you are acting as the assignee of one or more customer. In such cases, these procedures will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by you before you may invoke any right to arbitration under this section.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Manual in order to initiate the Dispute process.

If the parties are unable to resolve any Dispute within 60 days after notice, either party may submit the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA"). The arbitrators will use the AAA Healthcare Payor Provider Arbitration Rules, as amended. However, if a case involves a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used. The arbitrator(s) will be selected from the AAA National Healthcare Roster or the AAA's National Roster of Arbitrators. Unless otherwise agreed in writing, arbitration must be initiated within one year after the date on which written notice of the Dispute was given, or any appeal process described in the Administrative Manual, whichever is later. If arbitration is not initiated in that time frame, the right to pursue the Dispute in any forum is waived.

Any arbitration proceeding under this Agreement will be conducted in Davidson County, Tennessee. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from this provision of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this provision. While the arbitration remains pending, the termination for breach will not take effect.

This provision will survive any termination of this Agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

AGREED BY:

Medical Group (print):	Address to be used for giving notice under the agreement:
Cumberland County Board Of Education	
Signature:	Street: 368 FOURTH ST
Print Name and Title:	City: CROSSVILLE
DBA (if applicable):	State: TN
Date:	Zip Code: 38555
Email:	TIN: 626000551
National Provider Identification (NPI) Number:	1427300995

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Tennessee, Inc., UnitedHealthcare Plan of the River Valley, Inc., and its other affiliates, as signed by its authorized representative:

Signature: _____

Print Name: _____

Title: _____

Date: _____

For office use only:

Deal Number: 33279472

Month, day and year in which agreement is first effective:

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2	**Definitions, Products and Services** This appendix sets forth definitions for our "customer" and "participating entities" as well as lists the type of benefit contracts offered to our customers.
Payment Appendices	**Fee Information Document includes:** Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427 or through our website at www.UHCprovider.com.
Appendix 3	This document provides information about the members of your professional staff.
Appendix 4	This document provides information about your practice locations.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are set forth in this appendix.
Medicare Regulatory Requirements Appendix	(This appendix applies only if you are in our Medicare network.) Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendix(ices) apply only if you are in our Medicaid and/or CHIP network.) Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in these appendix(ices).
Administrative Manual	For the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of one or more provider manuals ("Administrative Manuals"). When this Agreement refers to protocols or reimbursement policies, it is also referring to the Administrative Manuals. For benefit contracts subject to a particular Administrative Manual, the Administrative Manual controls if it conflicts with a provision of this Agreement. However, the Administrative Manual does not control where it conflicts with applicable statutes and regulations. The Administrative Manuals will be made available to you on a designated website and upon request. The names of the Administrative Manuals, the websites to view and download them, and the benefit contracts to which they apply, are listed in Table 1 below. We may change the location of a website or the customer identification card identifier used to identify customers subject to a given Administrative Manual; if we do so, we will inform you.

<table>
<tr><td></td><td>We may make changes to the Administrative Manuals or other administrative protocols upon 30 days electronic or written notice to you.

Table 1.
<table><tr><th>Type of Benefit Contract</th><th>Description of Applicable Administrative Manual</th><th>Website</th></tr><tr><td>Tennessee Medicaid Benefit Contracts</td><td>UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Manual for Medicaid</td><td>www.UHCprovider.com</td></tr><tr><td>Tennessee CoverKids Benefit Contracts</td><td>UnitedHealthcare Community Plan of Tennessee Provider Manual</td><td>www.UHCprovider.com</td></tr></table></td></tr>
<tr><td>Credentialing Plan</td><td>To review our credentialing plan, visit www.UHCprovider.com.

This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427.</td></tr>
</table>

Appendix 2
Definitions, Products and Services

Section 1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase "customer" in this agreement.

Section 2. Participating entities. The following entities have access to our agreement:

- UnitedHealthcare Insurance Company and its affiliates
- Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.

Section 3. Products and services.

a. We may allow participating entities to access your services under this agreement for the benefit contract types described in each line item below, unless otherwise specified in section 3b of this Appendix 2:

b. This agreement does not apply to benefit contracts other than those described in section 3a, above.

Note: Excluding certain benefit contracts or programs from this agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for your participation in a network for such benefit contracts or programs.

Section 4. Definitions:

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions in this Appendix 2 regarding customer identification cards. If that happens, section 3a or section 3b of this Appendix will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the definitions in this Appendix 2 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

Payment Appendix – Tennessee Medicaid for Physicians

Tennessee Medicaid Fee Information Document for Physicians: TN 9126A

This Payment Appendix applies to covered services rendered by you to customers covered by Tennessee Medicaid Benefit Contracts, as described in this agreement.

Payment Appendix – Tennessee Medicaid for Non-Physician Professionals

Tennessee Medicaid Fee Information Document for Non-Physician Professionals: TN 9126A

This Payment Appendix applies to covered services rendered by you to customers covered by Tennessee Medicaid Benefit Contracts, as described in this agreement.

You will list the non-physician professional as the provider of service on claims when the non-physician professional provides a service to a customer. In the event that both a non-physician professional and a physician provide services to the same customer during the same encounter, then, subject to applicable reimbursement policies (for example the anesthesia reimbursement policy), either but not both the non-

physician professional or the physician may bill as the provider of service on the claim in accordance with CMS.

Payment Appendix – Tennessee CoverKids for Physicians

Applicability

The provisions of this Payment Appendix apply to covered services rendered by you to customers covered by Tennessee CoverKids Benefit Contracts, as described in this agreement.

Payment for Covered Services

Payer will pay claims for covered services according to the lesser of your customary charge or the applicable fee schedule, and in accordance with payment policies.

Tennessee CoverKids Fee Information Document for Physicians: TN 9126A

Payment Appendix –Tennessee CoverKids for Non-Physician Professionals

Applicability

The provisions of this Payment Appendix apply to covered services rendered by you to customers covered by Tennessee CoverKids Benefit Contracts, as described in this agreement.

Payment for Covered Services

Payer will pay claims for covered services according to the lesser of your customary charge or the applicable fee schedule, and in accordance with payment policies.

Tennessee CoverKids Fee Information Document for Non-Physician Professionals: TN 9126A

You will list the non-physician professional as the provider of service on claims when the non-physician professional provides a service to a customer. In the event that both a non-physician professional and a physician provide services to the same customer during the same encounter, then, subject to applicable reimbursement policies (for example the anesthesia reimbursement policy), either but not both the non-physician professional or the physician may bill as the provider of service on the claim in accordance with CMS.

Appendix 3
Professional Roster

IMPORTANT NOTE: You acknowledge your obligation under the agreement to notify us of any change in your professionals. Failure to do so may result in denial of claims or incorrect payment.

You represent that you have provided us with a Professional Roster that includes all of the following data elements for the physicians and other professionals on your staff:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific professional, you will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

Appendix 4
Your Practice Locations

Medical Group attests that this Appendix identifies all services and locations covered under this Agreement.

BILLING ADDRESS
All sites of service billing under all TINs listed in Appendix 4 must be included as par providers.

Practice Name Cumberland County Board Of Education

Street Address 368 Fourth St

City Crossville State TN Zip 38555

Tax ID Number (TIN) 626000551

National Provider ID (NPI) Number 1427300995

PRACTICE LOCATIONS (complete one for each service location)

Primary Practice Location Address:	Address: 368 FOURTH ST		
	City: CROSSVILLE	State: TN	Zip: 38555
	Tel #: (423) 622-1551	Fax #: (877) 856-7133, (423) 622-1556	
Billing Address:	Address: PO BOX 8114		
	City: CHATTANOOGA	State: TN	Zip: 37414
	Tel #: (423) 622-1551	Fax #: (877) 856-7133, (423) 622-1556	

Additional Service Location Address:	Address: 368 FOURTH ST		
	City: CROSSVILLE	State: TN	Zip: 38555
	Tel #: (423) 622-1551	Fax #: (877) 856-7133, (423) 622-1556	
Billing Address:	Address: PO BOX 8114		
	City: CHATTANOOGA	State: TN	Zip: 37414
	Tel #: (423) 622-1551	Fax #: (877) 856-7133, (423) 622-1556	

Mailing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	

TENNCARE PROGRAM

REGULATORY REQUIREMENTS APPENDIX

(Division of TennCare Required Language - Provider Agreements)

PROVIDER

THIS TENNCARE PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to State of Tennessee Medicaid Program benefit plans sponsored, issued or administered by **UnitedHealthcare Plan of the River Valley, Inc.** and Affiliates (referred to in this Appendix as "United") under the TennCare program ("TennCare") as governed by the State's designated regulatory agencies. Effective January 1, 2021, the requirements of this Appendix (unless otherwise specified below) shall also apply to CoverKids. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that United shall be permitted to unilaterally initiate such additions, deletions or modifications through an amendment to the Provider's Agreement.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable CRA, the definitions shall have the meaning set forth under the applicable CRA.

2.1 **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. For purposes of this Appendix and Agreement, such Affiliates may be referred to as UnitedHealthcare Plan of the River Valley, Inc., UPRV, River Valley Plan and UnitedHealthcare Community Plan.

2.3 **Division of TennCare:** The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers TennCare. For the purposes of the State Contract, the Agreement and this Appendix, Division of TennCare shall mean the State of Tennessee and its representatives.

2.4 **Care Coordinator:** The individual who has primary responsibility for performance of care coordination activities for a TennCare Covered Person receiving Long-Term Services and Supports as specified in this Appendix and meets the qualifications specified in the CRA.

2.5 **Support Coordinator:** The individual who has primary responsibility for support coordination activities for a TennCare Covered Person receiving Employment and Community First (ECF) CHOICES services as specified in this Appendix and meets the qualifications specified in the CRA. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be performed by the Integrated Support Coordination Team, as defined in the CRA.

2.6 **Independent Support Coordinator:** The individual who has primary responsibility for support coordination activities, including assistance in developing a PCSP, for a TennCare Covered Person receiving HCBS pursuant to a Section 1915(c) waiver.

2.7 **Contractor Risk Agreement (CRA) or State Contract:** The agreement between United and Division of TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and/or Employment and Community First (ECF) CHOICES, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare.

2.8 **Covered Person:** A person who has been determined eligible for TennCare or CoverKids and who has been enrolled with United for the provision of Covered Services under TennCare or CoverKids. A Covered Person may also be referred to as an Enrollee, Member, Customer or Patient under the Agreement. For purposes of Section 4.15, and missed visits of home health services in Section 4.15(c), "Covered Person" means not only (1) the Covered Person, (2) the Covered Person's parent, or (3) the Covered Person's legal guardian, but also a person who has a close, personal relationship with the Covered Person and is routinely involved in providing unpaid support and assistance to them.

2.9 **Covered Services:** The package of health care services, including physical health, behavioral health, and Long-Term Services and Supports, that define the covered services or benefits available to TennCare or CoverKids Enrollees enrolled with United pursuant to the State Contract.

2.10 **CoverKids:** The State Child Health plan under Title XXI of the Social Security Act State Children's Health Insurance Program.

2.11 **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (see 42 CFR 455.2).

2.12 **Home and Community-Based Services (HCBS):** Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES, ECF CHOICES and Section 1915(c) waiver HCBS are eligible for Consumer Direction. CHOICES, ECF CHOICES and Section 1915(c) waiver HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost

neutrality cap. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on comparable cost of institutional care.

2.13 Individual Program Plan (IPP): The plan for individuals with intellectual disabilities in intermediate care facilities, developed by the facility's interdisciplinary team, which includes opportunities for individual choice and self-management and identifies: the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

2.14 Person Centered Support Plan (PCSP): The plan for individuals receiving HCBS pursuant to CHOICES, ECF CHOICES, or a Section 1915(c) waiver developed by a Support Coordinator, or with assistance of an Independent Support Coordinator, in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals.

2.15 Long-Term Services and Supports (LTSS): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money. Long-Term Services and Supports are provided under the CHOICES, ECF CHOICES, 1915(c) HCBS Waivers, PACE program, and to individuals in ICF/IIDs, of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

2.16 Medical Records: All medical, behavioral health, and Long-Term Services and Supports histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and Long-Term Services and Supports documentation in written or electronic format; and analyses of such information.

2.17 Patient Liability: The amount of a Covered Person's income, as determined by the Division of TennCare, to be collected each month to help pay for the Covered Person's Long-Term Services and Supports.

2.18 Provider Manual: The TennCare Program Provider Manual is the administrative guide for providers that includes additional information, protocols and United policies. The Provider Manual is available on the website at www.uhccommunityplan.com.

2.19 Reportable Event: An event that is classified as Tier 1 or Tier 2, or Additional Reportable Events, as defined by TennCare, that must be reported to United and DIDD, as specified by TennCare, pursuant to Section A.2.15.7 of the CRA.

2.20 State: The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector

General, the Division of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Substance Abuse Services, Tennessee Department of Intellectual and Developmental Disabilities (DIDD), the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General or any other designated regulatory agencies.

2.21 **State Contract or Contractor Risk Agreement (CRA):** The agreement between United and Division of TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES, ECF CHOICES and CoverKids, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare. The CRA is available to the Provider on the Division of TennCare website.

2.22 **TennCare or TennCare Program:** The program administered by the Division of TennCare, as designated by the State and the Centers for Medicare and Medicaid Services (CMS), pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of this Appendix, references to TennCare or the TennCare Program shall include CoverKids unless otherwise specified.

2.23 **TennCare Kids (EPSDT):** The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations of EPSDT are in 42 CFR Part 441, Subpart B. In accordance with the CoverKids State Plan and Division of TennCare rules and regulations, EPSDT shall not apply to CoverKids Members.

2.24 **Tennessee Health Link:** The State defines Tennessee Health Link as a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of Covered Persons with behavioral health conditions. Covered Persons who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns, or functional need. They will be identified through a combination of claims analysis and provider referral. Specific requirements for Providers that are Tennessee Health Link Providers are noted herein.

2.25 **Waste:** The overutilization, underutilization, or other misuse of resources that result in unnecessary costs to the Medicaid program, such as providing services that are not medically necessary.

SECTION 3
PROVIDER REQUIREMENTS

The TennCare program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

3.1 **Provision of Covered Services.** Provider may not refuse to provide Medically Necessary or preventive Covered Services to a child under the age of twenty-one (21) or other Covered Persons for non-medical reasons. Provider is not required to accept or continue treatment of a patient

with whom Provider feels he or she cannot establish and/or maintain a professional relationship. Provider shall follow the applicable CRA's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

ii) Emergency Services: Covered Services (inpatient and outpatient) that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition. United shall provide coverage for an Emergency Medical Condition and any necessary Emergency Services, and Emergency Services shall be rendered by Provider without a requirement of prior authorization of any kind.

iii) Medically Necessary: Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary", as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16.

3.2 Non-Covered Services. As specified in section A.2.10 of the CRA, Provider acknowledges and agrees that, except as authorized pursuant to section A.2.6.5 of the CRA, and in accordance with applicable the Division of TennCare rules and regulations at 1200.13.13.10 and 1200.13.14.10, United shall not pay for non-Covered Services.

3.3 Scope of Practice/Services. By signing the Agreement, Provider certifies that Provider shall provide to Covered Persons only the Covered Services specified in the Agreement and that such services are within the scope of Provider's professional/technical practice.

3.4 Medicaid Eligibility; NPI. Provider must meet applicable minimum requirements for participation in TennCare, including a State Medicaid ID number as required by the Division of TennCare, and as applicable, Provider shall obtain a National Provider Identification Number (NPI). Upon notification from the State that Provider's enrollment in TennCare has been denied or terminated, United must terminate provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network.

3.5 Accessibility Standards. Provider shall comply with applicable access requirements, including but not limited to appointments and wait times, established under the CRA, as further described in the Provider Manual.

3.6 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.7 Hold Harmless. As specified in section A.2.6.7 of the CRA, Provider or collection agencies acting on Provider's behalf may not bill Covered Persons for amounts other than applicable TennCare cost sharing or Patient Liability amounts for Covered Services, including but not limited to, services that the State or United has not paid for, except as permitted by the Division of TennCare rules and regulations and as described below. Providers may seek payment from a Covered Person only in the following situations:

i) If the services are not Covered Services and, prior to providing the services, Provider informed Covered Person that the services are not Covered Serves. Provider shall inform the Covered Person of the non-Covered Service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once Provider bills United for the service that has been provided, the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

ii) If the Covered Person's TennCare eligibility is pending at the time services are provided and if Provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once the provider bills United for the service the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

iii) If the Covered Person's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing or Patient Liability amounts shall be refunded when a claim is submitted to United because Provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); and

iv) If the services are not covered because they are in excess of the Covered Person's benefit limit, and Provider complies with applicable TennCare rules and regulations.

As a condition of payment, Provider shall accept the amount paid by United or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the Covered Person's third party payer) plus any applicable amount of TennCare cost sharing or Patient Liability responsibilities due from the Covered Person as payment in full for the service. Except in the circumstances described above, if United is aware that Provider, or a collection agency acting on Provider's behalf, bills a Covered Person for amounts other than the applicable amount of TennCare cost sharing or Patient Liability responsibilities due from the Covered Person, United shall notify the Provider and demand that Provider and/or collection agency cease such action against the Covered Person immediately. If Provider continues to bill a Covered Person after notification by United, United shall refer the provider to the Tennessee Bureau of Investigation. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable. For purposes of this Section 3.7, Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.8 Indemnification.

i) Provider shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all injuries, deaths, claims, losses, damages, liabilities, judgements, costs (including court costs and attorney fees), expenses or suits incurred by or brought against the Indemnified Parties to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees, or contractors arising from the Agreement or as a result of the failure of Provider to comply with the terms of the CRA. The State shall give United and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to United or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

ii) Provider shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from Provider's or Indemnified Parties performance under the CRA. In any such action, brought against the Indemnified Parties, Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give United and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to United or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

iii) While the State will not provide a contractual indemnification to Provider, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to Provider. Provider retains all of its rights to seek legal remedies against the State for losses Provider may incur in connection with the furnishing of services under the Agreement or this Appendix, in accordance with the terms of the CRA, or for the failure of the State to meet its obligations under the CRA.

This section does not apply to governmental entities that are exempt from this indemnification requirement.

3.9 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If United delegates credentialing to Provider, United will provide monitoring and oversight and Provider shall ensure that providers, including Long-Term Services and Supports providers and all licensed medical professionals are credentialed in accordance with United's and the CRA's credentialing requirements.

3.10 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.11 Subcontracts. Provider shall not enter into subsequent agreements or subcontracts for any of the work contemplated under the Agreement or this Appendix without the prior written approval of United. If Provider subcontracts or delegates any functions of the Agreement, in accordance

with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the CRA and applicable laws and regulations, and subcontractor shall be subject to the same credentialing standards and audits as a contracted provider. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional TennCare requirements that may apply to the services. Provider agrees and acknowledges that subcontracts require prior approval by the Division of TennCare and Tennessee Department of Commerce and Insurance (TDCI).

In the event Provider does not obtain approval from United to enter into subsequent agreements or subcontracts, those subsequent agreements and/or subcontracts may be declared null and void by the Division of TennCare and claims submitted for such services shall be considered improper payments and may be considered false claims. Any such improper payment may be subject to action under Federal and State false claims statute or be subject to recoupment by United and/or Division of TennCare as overpayments.

3.12 Records Retention. As required under State or federal law or the CRA, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons, including without limitation, all grievance and appeal records and any other records related to services provided under the State Contract. Provider shall have and maintain documentation necessary to demonstrate that Covered Services were provided in compliance with State and federal requirements. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by the Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than ten (10) years after the termination of the Agreement. If records are under evaluation, audit, review, investigation or prosecution, they must be retained for a minimum of ten (10) years following resolution of such action (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of Covered Services performed under the Agreement and administrative, civil or criminal investigations or prosecutions).

i) Medical Records. Provider shall maintain Medical Records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Provider shall develop and maintain Medical Record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for Medical Record documentation. Provider shall distribute these policies to any additional practice sites. At a minimum, the policies and procedures shall address:

a) confidentiality of Medical Records;

b) Medical Record documentation standards; and

c) the Medical Record keeping system and standards for the availability of Medical Records. At a minimum the following shall apply: (1) as applicable, Medical Records shall be maintained or available at the site where Covered Services are rendered; (2) Covered Persons (for purposes of behavioral health records, Covered Person includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the Covered Person's Medical Records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges,

(except otherwise provided in the CRA) be given copies thereof upon request; (3) provisions for ensuring that, in the event a Covered Person-provider relationship with a TennCare PCP ends and the Covered Person requests that medical records be sent to a second TennCare provider who will be the Covered Person's PCP, the first provider does not charge the Covered Person or the second provider for providing the Medical Records; and (4) performance goals to assess the quality of Medical Record keeping.

ii) Behavioral Health Providers. As applicable, behavioral health providers shall maintain Medical Records in conformity with TCA 33-3-101 et seq. for persons with serious emotional disturbance or mental illness. Behavioral health providers shall also maintain Medical Records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

iii) General Record Keeping; Audit or Investigation. Provider acknowledges and agrees that the Division of TennCare, Department of Health and Human Services Office of Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD), Office of Inspector General (OIG), Department of Justice (DOJ), and the Office of the Attorney General, as well as any authorized State or federal agency or entity or their authorized representatives may evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including, but not limited to, Medical Records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services, and /or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of Provider. Upon request, Provider shall assist in such reviews, including the provision of complete copies of Medical Records. Any authorized State or federal agency or entity, including, but not limited to, the Division of TennCare, OIG, TBI MFCD, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, and the Office of the Attorney General, may use these records and information for administrative, civil or criminal investigations and prosecutions. For purposes of clarity with respect to this Section, HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCD, DHHS OIG, DOJ, and the Office of the Attorney General.

3.13 Availability of Records. Provider acknowledges and agrees that the Division of TennCare representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TennCare, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Division (TBI MFCD), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), the Office of the Attorney General, and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to Covered Persons as specified in section A.2.25.5 of the CRA.

3.14 Government Inspection. Provider shall make all records (including but not limited to, financial, administrative and Medical Records) available at Provider's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, the Division of TennCare, the Office of the Attorney General, or any duly authorized state or federal agency,

upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCD, DHHS OIG, DOJ, and the Office of the Attorney General, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. Provider shall send all records to be sent by mail to the Division of TennCare within twenty (20) business days of request unless otherwise specified by the Division of TennCare or applicable TennCare rules and regulations. Requested records shall be provided at no expense to the Division of TennCare, authorized federal, State, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, the Office of the Attorney General, or any duly authorized State or federal agency. Records related to appeals shall be forwarded within the time frames specified by in the appeal process portion of the CRA. Provider acknowledges and agrees that such requests made by TennCare shall not be unreasonable. Records shall be provided by Provider to the requesting agency at no cost.

As a condition of participation in TennCare, Covered Persons and Provider shall give TennCare or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), DOJ, the Office of the Attorney General, and any other authorized state or federal agency, access to their records. Provider shall furnish, immediately upon request, said records for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions.

TennCare or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), DOJ, the Office of the Attorney General, and any other authorized state or federal agency shall at any time have the right to inspect, audit, or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where TennCare-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the end date of the State Contract or from the date of completion of any audit, whichever is later.

3.15 Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to the Agreement, as well as medical information relating to the Covered Persons as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in the CRA. Records other than Medical Records may be kept in an original paper state or preserved on micromedia or electronic format. Medical Records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to Tenncare, OIG, TBI MFCD, DOJ and the DHHS OIG, Office of the Comptroller of the Treasury, and the Office of the Attorney General personnel during the Agreement period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the CRA contract period, these records shall be available at Provider's chosen location in Tennessee subject to the

written approval of United and TennCare. If the records need to be sent to TennCare, United shall bear the expense of delivery. Prior approval of the disposition of Provider's records must be requested and approved by TennCare in writing.

3.16 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, CRA sections A.2.27 (HIPAA) and E.6 (Confidentiality), as may be amended from time to time. Provider and its employees, providers, agents and subcontractors shall maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of all protected health information ("PHI") it receives or possesses in the course of carrying out the responsibilities of the Agreement.

3.17 Compliance with Law. Provider shall comply with and this Agreement incorporates by reference all applicable federal and State laws including Division of TennCare rules and regulations, guidelines, consent decrees or court orders; and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the Agreement as they become effective, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act, and Section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

iv) Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud

exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.18 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. All PIPs must receive prior approval from the Division of TennCare and TDCI.

3.19 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: Provider shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.20 Conflict of Interest. Provider shall cooperate with United's policies and procedures and comply with section E.28 of the CRA related to detecting and preventing conflicts of interest from occurring at all levels.

3.21 Gratuities. By signing the Agreement, Provider certifies that no member of or delegate of Congress, nor any elected or appointed official or employee of the State, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining the Agreement. The Agreement may be

terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from Provider or its agent or employees.

3.22 Excluded Individuals and Entities. Provider and its subcontractors shall comply with 42 C.F.R § 1002, related to exclusion and debarment screening. By signing the Agreement, Provider certifies that neither it nor any of its principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement are:

i) excluded from participation in federal health care programs under either Sections 1128 or 1156 of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

iii) are otherwise not in good standing with TennCare.

Provider is obligated to screen its employees and contractors ("Screened Persons") initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall screen its employees and contractors against the Social Security Master Death File. Provider shall not employ or contract with an individual or entity that has been excluded, debarred, suspended or otherwise ineligible to participate in Federal Health Care Programs or convicted of a criminal offense that falls within the realm of 42 U.S.C. § 1320a-7(a) ("Ineligible Persons"). Provider shall immediately report to United any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons. Provider can search the lists of excluded individuals (the "Exclusion Lists") on the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) https://www.npdb.hrsa.gov/ and the Excluded Parties List System (EPLS) http://www.epls.gov. Federal and state exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

If Provider determines that a Screened Person has become and Ineligible Person, then Provider will take appropriate action to remove such Screened Person from responsibility for, or involvement with, Provider's professional or business operations related to the Federal Health Care Programs and shall remove such Screened Person from any position for which the Screened Person's compensation or the items or services furnished, ordered, or prescribed by the Screened Person are paid in whole or part, directly or indirectly, by Federal Health Care Programs or otherwise with Federal funds at least until such time as the Screened Person is reinstated into participation in the Federal Health Care Programs. Any unallowable Federal funds made to an excluded individual as full or partial wages and/or benefits shall be refunded to United and/or the State, as applicable.

If Provider determined that a Screened Person is an Ineligible Person charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a) or is proposed for exclusion during the Screened Person's employment or contract term, Provider shall take all appropriate actions to ensure that the responsibilities of that Screened Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal Health Care Program.

3.23 Background Checks. Provider shall conduct criminal background checks and registry checks in accordance with State law and TennCare policy.

3.24 Disclosure. Provider shall comply and submit to United disclosure of information in accordance with the requirements, including timeframes, specified in 42 C.F.R. Part 455, Subpart B and TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.

3.25 Cultural Competency and Access, Language Services and Nondiscrimination Investigation. Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those individuals with physical or mental disabilities, with limited English proficiency and diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation, or gender identity, and shall provide interpreter services in a Covered Person's primary language and for those who are deaf or hard of hearing for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand and shall have written procedures for the provision of language interpretation and translation services for any Covered Person who needs such services. Provider further agrees to cooperate with the Division of TennCare and United during any discrimination complaint investigation and Provider shall assist Covered Persons with obtaining discrimination compliant forms and contact information for United's nondiscrimination office. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.26 Marketing. As required under State or federal law or the applicable CRA, any marketing materials developed and distributed by Provider as related to the performance of the Agreement, and any materials distributed to Covered Persons that use TennCare's name or trademark, must be submitted to United to submit to the Division of TennCare for prior approval. This prohibition shall not include references to whether or not the provider accepts TennCare.

3.27 Fraud, Waste and Abuse Prevention. As a condition of payment, Provider shall comply with section A.2.20 of the CRA and shall cooperate fully with the State's and United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the CRA and shall cooperate and assist the Division of TennCare and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if Provider makes or receives annual payments under TennCare of at least $5,000,000, Provider must establish certain minimum written policies and

information communicated though an employee handbook relating to the Federal False Claims Act in accordance with 42 C.F.R. § 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

Any suspected Fraud, Waste, or Abuse shall promptly be reported to UHC, the State Medicaid Program Integrity Unit or to the TBI State Medicaid Fraud Control Division. Any suspected enrollee or member Fraud, Waste, or Abuse shall promptly be reported to the Office of the Inspector General. Member or provider fraud reporting forms can be accessed at https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. You may also email TBI.MFCD@tn.gov or ProgramIntegrity.TennCare@tn.gov to report Fraud, Waste, or Abuse.

3.28 Data Submission.

i) Reports. Provider shall cooperate with and release to United any information necessary for United to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by United, in the format specified by United. Such reports shall include child and adolescent health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. Data must be provided at the frequency and level of detail specified by United or the State. By submitting data to United, Provider represents and attests to United that the data is accurate, complete and truthful and, upon United's request, Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

ii) Encounter Data. Provider agrees to cooperate with United to comply with United's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets United requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful and, upon United's request, Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

iii) Claims Information. Provider shall promptly submit to United (as set forth in the Agreement) the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and, if applicable, shall seek such third party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are: 1) Medically Necessary; and 2) have been provided to the Covered Person prior to submitting the claim.

3.29 Mandatory Reporting of Abuse. Provider shall report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.

3.30 TennCare Children. Provider shall not encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or Long-Term Services and Supports Covered Services.

3.31 Claims Information. United shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and the CRA, as may be amended from time to time.

i) Payment. Provider shall promptly submit to United information needed to make payment. Provider shall have one hundred twenty (120) calendar days from the date of rendering a Covered Service to file a claim with United, except (1) in situations regarding coordination of benefits or subrogation, in which case Provider is pursuing payment from a third party or (2) if a Covered Person is enrolled in United with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in United with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that United receives notification from the Division of TennCare of the Covered Person's eligibility/enrollment.

ii) Denial. The TennCare Provider Independent Review of Disputed Claims process shall be available to Provider to resolve claims denied in whole or in part by United as provided in TCA 56-32-126(b).

3.32 Capitation Payments. If Provider is compensated via a capitation arrangement, Provider must:

i) Immediately notify United and the Division of TennCare by certified mail, return receipt requested, if Provider becomes aware for any reason that he or she is not entitled to capitation payment for a particular Covered Person (for example, if an Covered Person dies); and

ii) Submit utilization or encounter data as specified by United so as to ensure United's ability to submit encounter data to the Division of TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

3.33 Overpayments. Provider shall notify United of any overpayments in compliance with the Affordable Care Act and TennCare policy and procedures. Provider shall report provider-identified overpayments to United and the TennCare Office of Program Integrity (OPI) in writing and shall return such overpayment within sixty (60) days from the date the overpayment is identified. Provider shall notify United in writing of the reason for the overpayment. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to State or federal law.

3.34 Health Care-Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by TennCare. As a condition of payment, Provider shall identify and report to United and TennCare any provider-preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438.3(g), and 447.26.

3.35 Reserved.

3.36 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance in the type and amounts appropriate to the services to be performed under the Agreement.

If Provider is a Tennessee State Agency, Provider shall not be required to provide, carry or maintain general liability insurance or medical, professional or hospital liability insurance in accordance with Title 9, Chapter 8 of the Tennessee Code Annotated. Claims against the State, or its employees, for injury, damages, expenses or attorney fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law.

If Provider is a Local Governmental Entity as set out under the Governmental Tort Liability Act in TCA 29-20-101, et seq., and as such, has its liability limits defined by law: As a Local Governmental Entity, Provider carries no insurance; however, it is self-insured for general liability in an adequately funded Self-Insurance Program up to the limits as set out in the statute. This self-insurance is for the benefit of the Local Governmental Entity only and provides no indemnification for any other entity whatsoever. The Local Governmental Entity does not have the authority under current law to indemnify other parties. The Local Governmental Entity agrees to produce proof of adequate professional liability insurance for Provider's professional employees who perform any professional services under this Agreement.

For a Provider rendering Long-Term Services and Supports Choices Nursing Facility services, ECF CHOICES services, and/or Home and Community Based Services, that is not a Local Governmental Entity or a State Agency, and does not provide short term skilled services:

For three (3) years following the effective date of TennCare's Long-Term Services and Supports Benefit Plan ("CHOICES or ECF CHOICES HCBS") implementation (the "Implementation Period"), United shall not require Provider to have liability insurance in excess of the TennCare requirements in effect prior to the Implementation Period. At the end of the Implementation Period, this Section shall automatically be amended without further action of the parties to reflect the current CHOICES HCBS insurance requirements. If CHOICES or ECF CHOICES HCBS has not implemented insurance requirements upon expiration of the Implementation Period, the parties agree to reevaluate and replace this paragraph with the then standard insurance requirements for similar providers. At all times, Provider agrees to maintain and provide written proof upon execution of the Agreement and at any subsequent time upon request of United of adequate insurance in such amounts as required by this paragraph. Provider agrees to notify United not less than fifteen (15) days prior to any reduction in coverage, cancellation or nonrenewal of the policy(s). The insurance required by this section shall not relieve or release Provider from, or limit its liability with respect to, any and all obligations under this Agreement.

3.37 Quality; Utilization Management. Provider agrees to participate and cooperate with any quality improvement, utilization review, and management activities established by United and/or the Division of TennCare, including actions to improve patient safety and quality. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the applicable CRA to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider.

3.38 Continuity of Care. In accordance with the Agreement and to the extent required by applicable law, regulations or the CRA, Provider shall cooperate with United and provide Covered Persons

with continuity of treatment (which may include coordination of care as required under law) in the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider, except in the case such termination is due to adverse action against the Provider.

Covered Persons receiving Tennessee Health Link Covered Services at the start date of Tennessee Health Link program operations shall be maintained in Tennessee Health Link until such time as the Covered Person no longer qualifies on the basis of medical necessity or refuses treatment.

3.39 Appeals and Grievances. United will provide general and targeted education to Provider regarding Provider's obligations related to appeals and grievances by Covered Persons as set forth in section A.2.19 of the CRA, including, without limitation, when an emergency appeal is appropriate, and procedures for providing written certification thereof. Provider shall comply with the appeal process, including, but not limited to, the following:

i) When a grievance or fair hearing request is filed by or on behalf of a Covered Person, Provider agrees to satisfy the following obligations in relation to the Covered Person's grievance or fair hearing request:

a. Provider must assist a Covered Person by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting grievances or TennCare fair hearing requests.

b. Provider may, with Covered Person's written consent, file a grievance or TennCare fair hearing request on Covered Person's behalf. However, provider cannot file a request for Covered Person to receive continuation of benefits.

c. Provider agrees to timely comply with a request from Covered Person, Covered Person's representative, TennCare or United for information or records, including medical records, related to Covered Person's grievance of fair hearing request.

ii) Provider must seek advance prior authorization when Provider feels he or she cannot order a drug on the TennCare PDL. Further, Provider shall take the initiative to seek prior authorization or change or cancel the prescription when contacted by a Covered Person or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

iii) Unless the State Contract requires otherwise, the appeals and grievances requirements above shall not apply to CoverKids Members. Review of CoverKids decisions shall be governed by TennCare Division rule 1200-13-21-.07 in accordance with T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

3.40 RESERVED

3.41 No Payment Outside U.S. Provider agrees that all Covered Services to be performed herein shall be performed in the United States of America and Provider agrees that United shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America. Furthermore, Provider is prohibited to transfer member data in any form via any medium to any third party beyond the boundaries and jurisdiction of the United States without the prior written consent of United.

3.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, nor use any policy or practice that has the effect of discriminating against, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, sexual orientation, gender identity, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and Enrollees. The Provider agrees to have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities. The Provider agrees to cooperate with TennCare and United during discrimination complaint investigations, and to report discrimination complaints and allegations to United, including allegations of any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse. The Provider agrees to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for United's Nondiscrimination Office.

3.43 Adverse Occurrences. Provider shall report adverse occurrences, including death, to United in accordance with applicable State requirements. The maximum timeframe for reporting an adverse occurrence to United shall be twenty-four (24) hours.

3.44 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract of otherwise required by law.

3.45 Advance Directives. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 C.F.R. Part 489, subpart I, 42 C.F.R. §§ 417.436(d), 422.128, and 438.3(j).

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Prenatal/Obstetric Care.

i. As applicable to Provider, unreasonable delay in providing care to a pregnant Covered Person seeking prenatal care shall be considered a material breach of the Agreement. For purposes of this Section 4.1, "unreasonable delay" shall mean failure of the prenatal care provider to meet the appointment availability requirements established under section A.2.11.5 of the CRA, as further described in the provider manual.

ii. As applicable to Provider, as a condition to reimbursement for global procedures codes for obstetric care, Provider shall submit utilization or encounter data as specified by United in a timely manner to support the individual services provided.

4.2 Laboratory Services. If Provider performs laboratory services, Provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3 CHOICES Program. If Provider renders Covered Services to Covered Persons under TennCare's program for Long-Term Services and Supports for individuals 65 and older and/or persons with physical, intellectual, or developmental disabilities, Provider shall notify United, in accordance with United's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services. United shall in turn notify the Covered Person's Care/Support Coordinator/ISC/DIDD Case Manager.

4.4 ECF CHOICES Program and Section 1915(c) waiver. If Provider renders Covered Services to Covered Persons under TennCare's program for people with Intellectual and/or Developmental Disabilities, Provider shall facilitate notification of the Covered Person's Support Coordinator by notifying United, in accordance with United's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services.

4.5 Hospitals. If Provider is a hospital, including a psychiatric hospital, Provider shall cooperate with United in developing and implementing protocols as part of United's nursing facility and ICF/IID diversion plan, which shall include, at a minimum, a hospital's obligation to promptly notify United upon admission of an eligible Covered Person regardless of payor source for the hospitalization, how a hospital will identify members who may need home health, private duty nursing, nursing facility or HCBS upon discharge, and how a hospital will engage United in the discharge planning process to ensure that Covered Persons receive the most appropriate and cost-effective medically necessary services upon discharge.

4.6 Pharmacy Services. Provider shall coordinate with the TennCare pharmacy benefits manager (PBM) regarding authorization and payment for pharmacy services.

4.7 Nursing Facility. If Provider is a nursing facility, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Promptly notify United, and/or the State as directed by the Division of TennCare, of a Covered Person's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a Covered Person's known circumstances. Provider shall also notify United, and/or the State as directed by Tenncare, prior to a Covered Person's discharge from the nursing facility;

ii) Provide written notice to the Division of TennCare and United in accordance with State and federal requirements before voluntarily terminating the Agreement. Provider shall comply with all applicable State and federal requirements regarding voluntary termination;

iii) Notify United immediately if Provider is considering discharging a Covered Person. Provider shall consult with the Covered Person's Care Coordinator to intervene in resolving issues if possible. If Provider is not able to resolve such issues, Provider shall prepare and implement a discharge and/or transition plan as appropriate;

iv) Notify a Covered Person and/or a Covered Person's representative (if applicable) in writing prior to discharge in accordance with State and federal requirements;

v) Provider shall accept payment or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the Covered Person's third party payer) plus the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from a Covered Person in excess of the amount of applicable Patient Liability. For purposes

of this Section 4.7(v), Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served;

vi) Provider's responsibilities regarding a Covered Person's Patient Liability as specified in sections A.2.6.7 and A.2.21.5 of the CRA, which shall include but not be limited to collecting the applicable Covered Person Patient Liability amounts from CHOICES Group 1 members, notifying the Covered Person's Care Coordinator if there is an issue with collecting a Covered Person's Patient Liability, and making good faith efforts to collect payment;

vii) Provider shall timely seek certification and recertification (as applicable) of a Covered Person's level of care eligibility for Level I and/or Level II nursing facility care and shall cooperate fully with United in the completion and submission of the level of care assessment;

viii) Provider shall notify United of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility for the currently authorized level of nursing facility services;

ix) Provider shall make available to United complete and accurate documentation related to Pre-Admission Evaluations (PAEs) such that United is able to submit such PAEs to TennCare that satisfy all technical requirements specified by TennCare.

x) Provider shall comply with State and federal laws and regulations applicable to nursing facilities as well as any applicable court orders, including, but not limited to, those that govern admission, transfer, and discharge policies;

xi) Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all CHOICES nursing facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact a Covered Person's need for or benefit from specialized services;

xii) Provider shall collaborate with United and other providers as needed to help ensure that current information regarding the Covered Person's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination;

xiii) Provider shall cooperate with United in developing and implementing protocols as part of United's CHOICES nursing facility diversion and transition plans, which shall include, at a minimum, Provider's obligation to promptly notify United upon a admission or request for admission of an eligible Covered Person regardless of payor source for the CHOICES nursing facility stay, how Provider will assist United in identifying residents who may want to transition from CHOICES nursing facility services to CHOICES HCBS; Provider's obligation to promptly notify United regarding all such identified members, and how Provider will work with United in assessing a Covered Person's transition potential and needs and in developing and implementing a transition plan (as applicable);

xiv) Provider shall coordinate with United in complying with the requirements in 42 C.F.R. 483.75, regarding written transfer agreements and shall use contract providers when

transfer is medically appropriate, except as authorized by United or for emergency services;

xv) Provider shall have on file a system designed and utilized to ensure the integrity of a Covered Person's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

xvi) Provider shall specify to United whether it will be contracted to provide SNF services at an Enhanced Respiratory Care (ERC) rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified). If Provider does enter into an agreement for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, including sub-acute and secretion management, Provider is required to be licensed by the Tennessee Department of Health to provide such specialized ERC, certified by CMS for program participation, and compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TennCare.

xvii) Provider shall immediately notify United of any changes in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

xviii) If Provider is involuntarily decertified by the Tennessee Department of Health or CMS, the Agreement will be automatically terminated in accordance with federal requirements; and

xix) The Agreement shall be assignable from United to the State, or its designee, at the State's discretion upon written notice to United and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of United.

xx) In the event there is a proposed change of ownership with any Nursing Facility, the new provider shall provide to the Division of TennCare documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider. United shall, subject to T.C.A 71-5-1412, enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with United, which shall include, but not be limited to, the assumption of the previous owner's agreement, a new agreement with United, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. For purposes of nursing facility changes of ownership only, United may provisionally credential the new provider based on credentialing completed for the previous provider to enable execution of an agreement prior to the change of ownership. In cases where the United utilizes provisional credentialing, United will subsequently conduct credentialing of the provider in accordance with the State Contract once the change of ownership process has fully concluded (including any actions related to licensure and/or certification). A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

4.8 CHOICES, ECF CHOICES, or Section 1915(c) waiver HCBS Providers. If Provider is a CHOICES, ECF CHOICES or Section 1915(c) waiver HCBS provider, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Provide at least sixty (60) days advance notice to United when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision. Provider shall cooperate with the Covered Person's Care or Support Coordinator, Support Coordinator, Independent Support Coordinator, or DIDD Case Manager to facilitate a seamless transition to alternate providers;

ii) In the event that a CHOICES, ECF CHOICES or 1915(c) waiver HCBS provider change is initiated for a Covered Person, regardless of any other provision of the Agreement, Provider shall continue to provide services to the Covered Person in accordance with the Covered Person's person-centered support plan ("PCSP"), as appropriate, until the Covered Person has been transitioned to a new provider, as determined by United, or as otherwise directed by United, which may exceed sixty (60) days from the date of notice to United, unless the Covered Person refuses continuation of services, the Covered Person's health and welfare would be otherwise at risk by remaining with Provider, or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm. Prior to discontinuing services to the Covered Person, or prior to Provider's termination of the Agreement, as applicable, Provider shall:

a) Provide a written notification of the planned service discontinuation to the Covered Person, his/her conservator or guardian, and his/her support coordinator, no less than sixty (60) days prior to the proposed date of service discontinuation or termination of the Agreement;

b) Obtain United's written approval, in the form of a signed PCSP, to discontinue the services and cooperate with the transition to any subsequent, authorized service provider as is necessary; and

c) Consult and cooperate with United in the preparation of a discharge plan for all Covered Persons receiving care and service from Provider in the event of a proposed termination of service. When appropriate, as part of the discharge plan, Provider shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.

iii) Provider's reimbursement shall be contingent upon the provision of Covered Services to an eligible Covered Person in accordance with applicable federal and state requirements and the Covered Person's plan of care as authorized by United, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the Covered Person receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service - – electronic visit verification that fully comports with the 21st Century Cures Act and TennCare requirements shall be deemed sufficient to meet this requirement;

iv) CHOICES or ECF CHOICES HCBS Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's Care or Support Coordinator;

V) Provider shall use the electronic visit verification system specified by United in accordance with United's requirements;

vi) Upon acceptance by Provider to provide approved services to a Covered Person as indicated in the Covered Person's PCSP, as appropriate, Provider shall ensure that it has staff sufficient to provide the service(s) authorized by United in accordance with the Covered Person's PCSP, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the Covered Person's service schedule;

vii) Provider shall provide back-up for its own staff if a staff member is unable to fulfill an assignment for any reason. Provider shall ensure that back-up staff meet the qualifications for the authorized Covered Service;

viii) Provider is prohibited from requiring a Covered Person to choose Provider as a provider of multiple services as a condition of providing any service to the Covered Person;

ix) Provider is prohibited from soliciting Covered Persons to receive services from Provider, including:

a) Referring an individual for CHOICES or ECF CHOICES screening and intake with the expectation that, should CHOICES or ECF CHOICES enrollment occur, Provider will be selected by the Covered Person as the service provider; or

b) Communicating with existing CHOICES, ECF CHOICES or Section 1915(c) waiver members via telephone, face-to-face or written communication for the purpose of petitioning the Covered Person to change providers;

c) Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES, ECF CHOICES or Section 1915(c) waiver members that should instead be referred to the person's MCO, AAAD or DIDD, as applicable;

x) Provider shall comply with Reportable Event reporting and management requirements as prescribed by TennCare, including those specified in Section A.2.15.7 of the CRA;

xi) Provider is not required to have liability insurance in excess of TennCare requirements in effect prior to the implementation of CHOICES or ECF CHOICES;

xii) Provider may not alter any official CHOICES, ECF CHOICES or 1915(c) waiver brochures or other materials unless United has submitted a request to do so to TennCare and obtained prior written approval from TennCare in accordance with section A.2.17 of the CRA;

xiii) Provider may not reproduce CHOICES or ECF CHOICES logos for its own use unless United has submitted a request to do so to TennCare and obtained prior written approval from TennCare; and

xiv) CHOICES, ECF CHOICES and 1915(c) waiver HCBS Providers are required to submit copies of current licensure and/or certification to United or to DIDD (as applicable);

xv) Provider will maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

xvi) If Provider is utilizing the Electronic Visit Verification (EVV) System, Provider shall ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and in a manner prior approved by TennCare.

xvii) In the event there is a proposed change of ownership of Provider, the new provider shall provide to the Division of TennCare documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any managed care contractor previously contracted with the former owner or operator. United and the new provider shall negotiate a new provider agreement in good faith. A new provider with a Medicaid ID and an executed contract with United, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with United, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with United, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with United. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

xix) Support Coordination provider agencies shall:

a) Ensure that all person employed to render support coordination services (Independent Support Coordinators or ISCs) receive effective guidance, mentoring, and training, including all training required by TENNCARE and DIDD. Effective training shall include opportunities to practice support coordination duties in a manner that development and mastery of essential job skills. The intent of providing independent support coordination is to ensure that planning and coordination of services is conflict-free. Thus, providers of independent support coordination services are prohibited from providing both support coordination and other direct waiver services. Support Coordination providers must maintain an office in each grand region where services are provided.

b) Provide Support Coordination services in a manner consistent with the 1915(c) waiver, TennCare rules, policies, and protocols and the State Contract.

c) Provide Support Coordination services in a manner that ensures person-centered planning processes and practices are followed in compliance with 42 CFR § 438.208 and 42 C.F.R. § 441.301(c)(4)-(6) and that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

d) Initiate and oversee at least annual reassessment of the individual's level of care eligibility, including initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the PCSP.

e) Support the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

f) Coordinate with United to support any person supported receiving HCBS and enrolled in the Statewide or CAC Waivers planning and implementing as seamless a transition as possible from EPSDT benefits to adult benefits, including any coordination of 1915c HCBS with State Plan HCBS – Home Health and Private Duty Nursing services, as applicable, and in accordance with the State Contract or TennCare policies and protocols.

g) Ensure compliance with and reporting of specified waiver performance measures related to the PCSP, including:

PCSP inclusion of a risk assessment;

PCSP inclusion of a medical assessment, whether applicable;

PCSP review and revision, as needed, prior to the annual due date;

PCSP revisions completed as needed to address member's changing needs; and

Ensure member received services for the amount, duration, and frequency as well as type and scope specified in the approved PCSP.

h) Track and report individual quality outcomes data as required by TENNCARE to measure provider and system performance.

i) United shall require that all 1915(c) waiver Independent Support Coordination providers participate in education and training activities as required by United to understand physical and behavioral health benefits, and collaborate with United to ensure continuity and coordination among physical health, behavioral health, and long-term services and supports, and to ensure collaboration among physical health, behavioral health, and long-term services and supports providers pursuant to protocols, policies and procedures developed or approved by TENNCARE.

If Provider is a CHOICES or ECF CHOICES HCBS provider who renders PERS, assistive technology, minor home modifications, or pest control services, Provider shall meet all the requirements of the State Contract, the Agreement and this Appendix, applicable to Provider's services under the Agreement.

4.9 TennCare Kids Services. As applicable to Provider, Provider acknowledges and agrees that Provider is aware of the benefits that TennCare Kids offers and which requires Provider to make treatment decisions based upon children's individual medical and behavioral health needs, in accordance with the requirements of Section A.2.7.6 of the CRA, which are incorporated into this Appendix and shall be provided to Provider upon request.

4.10 Local Health Department. If Provider is a local health department, Provider shall meet all the requirements of the Agreement and this Appendix (except those that apply to nursing facilities

and HCBS providers). In addition, the following apply for the purpose of TennCare Kids screening services:

i) Provider agrees to timely submit encounter data to United;

ii) United agrees to timely process claims for services in accordance with CRA Section A.2.22.4;

iii) Provider may terminate the Agreement for cause with thirty (30) days advance notice; and

iv) United agrees that prior authorization shall not be required for the provision of TennCare Kids screening services.

4.11 Referrals to Specialty Care Providers. If Provider is a Primary Care Physician ("PCP"), Provider will arrange for referrals to specialty care providers pursuant to the referral policies and procedures as described in the Provider Manual. Providers who are specialty care providers will comply with referral requirements, including but not limited to the following:

i) Maintain good communications with the Covered Person's PCP and contact the Covered Person's PCP if diagnosis or treatment required differs significantly from expectations indicated on the referral form;

ii) Respond in a timely manner to the Covered Person's PCP with summary of findings, test results, and recommendations following referral;

iii) Notify the Covered Person's PCP of the need for secondary referral within the TennCare network of physicians. Referral to other physicians outside of the TennCare network should be preceded by consultation and agreement with the Covered Person's PCP unless in the case of a medical emergency; and

iv) Hospitalize a Covered Person only with the knowledge and agreement of the Covered Person's PCP or in the case of medical emergency.

4.12 Reserved.

4.13 Ethical and Religious Directives. In the event the Agreement includes a provision limiting the services Provider will provide, the following is applicable:

i) The Provider shall provide a list to United of the services it does not deliver due to the Ethical and Religious Directives. United shall furnish this list to the Division of TennCare, notating those services that are TennCare covered services. This list shall be used by the United and the Division of TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

ii) At the time of service, the Provider shall inform TennCare members of the health care options that are available to the TennCare members, but are not being provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that United has additional information on providers and procedures that are covered by Division of TennCare.

4.14 ECF CHOICES and/or CHOICES CLS, CLS-FM, Section 1915(c) Providers. If Provider is an ECF CHOICES and/or CHOICES CLS, CLS-FM, or Section 1915(c) provider in addition to

the other requirements set forth in the Agreement or this Appendix, the following provision shall apply.

i) Residential Providers, shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

ii) Provider shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM Providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to member placement.

iii) Providers with provider-owned vehicles (including employee-owned vehicles used to transport members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.

iv) Provider shall designate a staff member as an Incident Management Coordinator who shall be trained on Reportable Event processes by the United as prescribed by TennCare. Such staff member shall be the Provider's lead for Reportable Events, be primarily responsible for tracking and analyzing Reportable Events pursuant to Section A.2.15.7.1.2, and be the United's main point of contact at the Provider agency for Reportable Events.

v) Provider shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by United. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

vi) Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to the following: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. Provider's policies and procedures concerning the complaint resolution process shall be available to the United upon request.

vii) As applicable, Providers providing assistance to a Covered Person with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician's orders. Provider shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to Covered Persons when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement preventions strategies.

viii) Provider shall develop and maintain policies approved by United that ensure Covered Persons are treated with dignity and respect, including ensuring staff obtain certification (as applicable) and training on person-centered practices and other topics as may be required pursuant to TENNCARE guidance or as otherwise required by the programs. Such policies shall include, but are not limited to:

a) Ensuring Covered Persons/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

b) Soliciting Covered Person/representative and family feedback on Provider services;

c) Ensuring the Covered Person/representative has information to make informed choices about available services;

d) Ensuring Covered Persons are allowed to exercise personal control and choice related to their possessions;

e) Supporting Covered Persons in exercising their rights;

f) Periodically reviewing Covered Persons' day services and promoting meaningful day activities, if applicable;

g) Supporting the Covered Person in pursuing employment goals; and

h) Only restricting Covered Persons' rights as provided in the Covered Person's person-centered support plan.

ix) Residential Providers shall develop and maintain policies to ensure that Covered Persons have good nutrition while being allowed to exercise personal choice and that Covered Persons' dietary and nutritional needs are met.

x) Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that Provider staff have all required licensure and certification. Additionally, all Providers shall ensure that staff receives ongoing supervision consistent with staff job functions. Providers shall ensure that the composition of the Provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the Provider serves and is representative of the people served.

xi) Residential Providers shall have policies and procedures to manage and protect Covered Persons' personal funds that comport with all applicable United and TennCare policies, procedures and protocols.

xii) Providers shall carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following:

a) Workers' Compensation/ Employers' Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.

b) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.

c) Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00). ECF

CHOICES providers requiring this coverage are limited to those expected to transport the member as a component of service delivery, as follows: individual and small group employment supports (including pre-employment services), personal assistance, supportive home care, community integration support services, community transportation, independent living skills training, community living supports, and community living supports-family model.

xiii) CHOICES and I/DD MLTSS Programs Providers shall allow DIDD staff access to pertinent Choices and I/DD MLTSS Program member documentation. in order for DIDD to perform its oversight role (applicable in CHOICES for Reportable Event Management and Quality Monitoring for specified services).

xiv) CHOICES and I/DD MLTSS Programs Providers are required to comply with DIDD investigations as prescribed by TennCare protocol.

4.15 Home Health Agencies. If Provider is a home health agency ("HHA"), in addition to the other requirements set forth in the Agreement or this Appendix, the following provisions shall apply.

i) Provider shall comply with the federal regulations delineating the conditions of participation that HHAs must meet in order to participate in the Medicaid program.

ii) Provider shall supply each Covered Person with the following:

a) Written and verbal notice of the Covered Person's rights and responsibilities as a home health patient as required under 42 CFR §484.50(a);

b) Written and verbal notice of Provider's policy for transfer and discharge as required under 42 CFR §484.50(d), including an explanation in plain language that disruptive, abusive, or uncooperative behaviors could give rise to a "discharge for cause," and the requirements that must be satisfied by Provider in order for transfer or a discharge to be effectuated;

c) Written and verbal notice of Provider's obligation to accept complaints made by the Covered Person about the care that is (or fails to be) furnished, and of Provider's obligation to investigate, document, and resolve these complaints (as well as complaints of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or misappropriation of the Covered Person's property by anyone furnishing care on behalf of Provider), as required under 42 CFR §484.50(e);

d) An explanation of the scope of the home health services that the Covered Person will be receiving. Afterwards, Provider must obtain the signature of the Covered Person verifying that a Provider staff member has explained the scope of services to the Covered Person. Likewise, Provider must obtain, as required under 42 C.F.R. § 484.50(a)(2), the Covered Person's or the legal representative's signature confirming that they received written notice of the Covered Person's rights and responsibilities as required by Section 4.15(ii)(a). Provider must maintain all signature(s) in their record of the Covered Person.

iii) **Missed Visits.**

a) Provider must develop a back-up plan for each Covered Person to be implemented during missed visits, or when otherwise necessary. For purposes of this section, "missed visit," refers to a period of one or more hours that a staff member of Provider does not furnish the home health service that a

Covered Person is authorized to receive and which has been implemented. A missed visit may be due to exigent circumstances beyond any party's control. It may also be due to a fault of Provider, the staff member, or United. It may also be due to a fault of the Covered Person. For example, the Covered Person refuses to allow the staff member to enter the home or to remain there after beginning work; the staff member suspects or witnesses unlawful activity in the home; or, the environment in the Covered Person's home is such that the staff member fears for their personal safety.

b) When Provider is notified before a missed visit occurs or as it is occurring, Provider must contact the Covered Person and implement the back-up plan or offer a suitable alternative service. Provider must report all missed visits to United in writing within three calendar days of the missed visit. This report must be submitted on a United-approved form, which captures all of the information United requires, including, but not limited to, the following: the identity of the Covered Person; the type of service involved; the date of the missed visit; the cause(s); and, what corrective action was taken to mitigate the cause(s) of the missed visit. Provider must ensure that the staff member enters notes about the circumstances of a missed visit in every instance in which notes are possible.

iv) When a conflict arises between a Covered Person and an assigned Provider staff member, or when a Covered Person refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify Provider. Once notified, Provider will contact the Covered Person and offer to either (1) implement the existing back-up plan or (2) staff the care with a qualified alternative staff member. In every instance, Provider must record these missed visits, as described above, and timely submit them to United. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing to the conflict. If additional conflicts arise between the Covered Person and Provider or alternative staff member (for example, if a Covered Person refuses to admit the alternative staff member into Covered Person's home), Provider must notify United and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until Provider, in its discretion, plans to discharge the Covered Person for cause. At that point, Provider must notify United of its decision to discharge or transfer the Covered Person.

4.16 Electronic Visit Verification (EVV). Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

4.17 Intermediate Care Facility for Individuals with Intellectual Disabilities Providers. If Provider is an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) provider, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Promptly notify United, and/or State entity as directed by the Division of TennCare, of a Covered Person's request for admission to the ICF/IID or when there is a change in a Covered Person's known circumstances and to notify United, and/or State entity as directed by Division of TennCare, prior to a member's discharge;

ii) Not admit any person to an ICF/IID for whom Medicaid reimbursement will be sought prior to completion of a Community Informed Choice process as prescribed by Division of TennCare, and approval of such admission by the State;

iii) Provide written notice to the Division of TennCare and United in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;

iv) Notify United prior to beginning to develop an involuntary discharge plan and to consult with United's IDD team to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate, including reasonable time to prepare the Covered Person and his/her parents or guardian for discharge or transfer;

v) Notify the Covered Person and/or the Covered Person's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements, including involving the member and their family or legal guardian in planning for any transfer or discharge. This process must include providing a summary of the Covered Person's course of stay in the ICF/IID, a final summary of the Covered Person's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the member's IPP as well as a post-discharge plan of care;

vi) Accept payment or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the member's third party payer) plus the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from a Covered Person in excess of the amount of applicable Patient Liability. For purposes of this Section 4.17(vi), Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served;

vii) Ensure compliance regarding a Covered Person's Patient Liability as specified in sections A.2.6.7 and A.2.21.5 of the CRA, which shall include but not be limited to collecting the applicable Covered Person Patient Liability amounts from CHOICES Group 1 members, notifying the Covered Person's Care Coordinator if there is an issue with collecting a Covered Person's Patient Liability, and making good faith efforts to collect payment;

viii) Provide timely certification and recertification (as applicable) of the Covered Person's level of care eligibility for ICF/IID services and level of need for and receipt of continuous active treatment, and cooperate fully with United in the completion and submission of the level of care assessment;

ix) Notify United of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility and level of need for and receipt of continuous active treatment;

x) Comply with state and federal laws and regulations applicable to ICFs/IID as well as any applicable federal court orders, including but not limited to the American with Disabilities Act and those that govern admission, transfer, and discharge policies;

xi) Cooperate with United in developing and implementing protocols as part of United's ICF/IID diversion and transition plans pursuant to the Americans with Disabilities Act (see Section A.2.9.7.7), which shall, include, at a minimum, the ICF/IID's obligation to

promptly notify United upon request for admission of an eligible Covered Person regardless of payor source for the ICF/IID stay; refusal of admission of any person to an ICF/IID for whom Medicaid reimbursement will be sought pending completion of a Community Informed Choice process as prescribed by TennCare, and approval of such admission by the State; how the ICF/IID will assist United in identifying current ICF/IID residents who may want to transition from ICF/IID services to home and community-based care; the ICF/IID's obligation to promptly notify United regarding all such identified members; and how the ICF/IID will work with United in assessing the Covered Person's transition potential and needs, and in developing and implementing a transition plan, pursuant to 42 C.F.R. 483.440;

xii) Have on file a system designed and utilized to ensure the integrity of the Covered Person's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

xii) Immediately notify United of any change in its license to operate as issued DIDD as well as any deficiencies cited during the federal certification or licensure process;

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and section A.2.22.4 of the CRA as may be amended from time to time. Payments made via electronic transfers shall include a signed ETF form that includes 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section. United shall pay Provider only for services (1) provided in accordance with the requirements of the CRA, United's policies and procedures as set forth in the Agreement and this Appendix, and State and federal law and (2) provided to Covered Persons enrolled with United. Provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service.

5.2 Third Party Liability. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the CRA. Provider shall identify third party liability coverage, including Medicare and long-term care insurance and if applicable, seek such third party liability payment before submitting claims to United. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the CRA.

5.3 Alternate Claims Processing. In the event that the Division of TennCare deems United unable to timely process and reimburse claims and requires United to submit Provider claims for reimbursement to an alternative claims processor to ensure timely reimbursement, Provider shall agree to accept reimbursement at United's contracted reimbursement rate or the rate established by the Division of TennCare, whichever is greater.

5.4 No Incentives to Limit Medically Necessary Services. United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Covered Person.

5.5 Provider Discrimination Prohibition. United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of

the provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.6 Communications with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment; or

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or authorization process to obtain necessary health care services.

5.7 Termination or Assignment of Agreement. In addition to its termination rights under the Agreement, United shall have the right to suspend, deny, refuse to renew or terminate the Agreement in accordance with the terms of the CRA section E.14 and applicable law and regulation.

To the extent applicable to Providers provision of Covered Services (as defined within this Appendix), the Agreement shall be assignable from United to the State, or its designee, at the State's discretion upon written notice to United and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of United.

5.8 Sanctions. United shall have the right to assess liquidated damages, sanctions, or reductions in payment for specific failures to comply with contractual or credentialing requirements. This shall include, but may not be limited to, Provider's failure or refusal to respond to United's request for information, request to provide Medical Records, or request to provide credentialing information. At United's discretion or a directive by TennCare, United shall impose financial penalties against Provider as appropriate. Such action shall be taken in accordance with the terms of the CRA and applicable law and regulation.

5.9 Provision of Materials to Provider. United will provide a copy of the applicable member handbook and Provider Manual to provider, and may do so via website at www.uhccommunityplan.com or other appropriate format.

5.10 Notice of Denied Authorizations. United will provide notice to Provider of any denied authorizations in accordance with the Provider Manual or other United policies and procedures.

5.11 Recoupment. United will not recoup payments made to Provider when the specific issue, services or claims that are the basis of the repayment are currently being investigated by TennCare or the State of Tennessee, are the subject of pending federal or State litigation, or are being audited by the TennCare Recovery Audit Contractor (RAC). United will seek permission from the Division of TennCare before initiating any recoupment of any program integrity related funds in compliance with section A.2.20.1.11 of the CRA, to ensure that the repayment is permissible. In the event United obtains funds in cases where repayment is prohibited, such funds shall be returned to Provider.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable CRA, as set forth in this Appendix, the Provider Manual, and protocols, policies and procedures that United has provided or delivered to Provider. No other terms or conditions agreed to by United and Provider shall negate or supersede the requirements of section A.2.12.9 or other applicable provisions of the CRA, which are incorporated into the Agreement by reference. It is United's responsibility to provide all necessary training and information to Provider to ensure satisfaction of all United's responsibilities specified under the CRA. Nothing in the Agreement relieves United of its responsibility under the CRA. If the Division of TennCare determines any provision of the Agreement is in conflict with provisions of the applicable CRA, the terms of the CRA shall control and the terms of the Agreement in conflict with those of the CRA will be considered null and void. All other provisions of the Agreement shall remain in full force and effect.

6.2 Monitoring. United shall perform ongoing monitoring of Provider and shall perform periodic formal reviews, whether announced or unannounced, of Provider and of Covered Services rendered to Covered Persons, consistent with the requirements of State and federal law and the applicable CRA. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the CRA and Provider shall take appropriate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or Long-Term Services and Supports which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by the Division of TennCare. Provider shall comply with any corrective action plan initiated by United.

6.3 Delegation. The parties agree that, prior to execution of the Agreement, United evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement if in United's reasonable judgment Provider's performance under the Agreement is inadequate.

6.4 Reassignment of Payment. Any assignment of TennCare funds or payments to billing agents or alternative payees and any reassignment of payment must be made in accordance with 42 CFR 447.10 and shall require an executed billing agent agreement or alternative payee assignment agreement. If the alternative payee assignment is on-going, United or Provider, as applicable, shall screen the billing agents and alternative payees initially and monthly through

the federal exclusion (LEIE) and debarment (EPLS) databases. Any direct or indirect payments to out of country individuals and/or entities are prohibited.

6.5 Entire Agreement. The Agreement, including the appendices, Provider Manual and policies and procedures referenced in, and incorporated into, the Agreement and this Appendix contain the entire agreement of United and Provider, and shall supersede all other oral agreements or negotiations between the parties. The Agreement, and any renewal of the Agreement, shall include a signature page which contains United's and Provider's names which are typed or legibly written, Provider's company with titles, and dated signatures of all appropriate parties and specify the effective date.

6.6 Amendment. This Agreement may be amended at any time by mutual agreement of the parties, provided that before any amendment shall be operative and valid, it shall be reduced to writing and signed by United and Provider and be attached to the Agreement. The only exception will be changes required to conform the contract to regulatory requirements required by the State of Tennessee as described in Section 1 of this Appendix. All notification of amended language will be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc.). Provider shall have thirty (30) days from the date that United sends notice of change to give notice of rejection. Notice of rejection shall constitute termination without cause and require Provider to follow the termination provisions outlined in the Agreement.

6.7 State Review and Approval. The Agreement and this Appendix, and any future revisions to the Agreement or this Appendix, are subject to advance approval of TDCI in accordance with applicable State law regarding the approval of a certificate of authority (COA) and any material modifications thereof. United shall revise the Agreement and this Appendix as directed by the Division of TennCare. Further, the Division of TennCare shall have the right to direct United to terminate or modify the Agreement when the Division of TennCare determines it to be in the best interest of the State.

6.8 Termination of CRA. United and Provider recognize and agree that in the event of termination of an applicable CRA, Provider shall immediately make available to the Division of TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to the Division of TennCare. Provider shall continue to provide Covered Services under the terms and conditions of the Agreement for up to forty-five (45) calendar days from the termination date or until Covered Persons can be transferred to another managed care organization, whichever is longer. United shall continue to reimburse Provider for Covered Services through the end of United's obligations under the CRA.

6.9 Governing Law. The parties acknowledge that any disputes arising out of TennCare program services or items provided pursuant to the CRA shall be governed by and construed in accordance with the law of the State of Tennessee.

6.10 Escalators. As provided at Section 2.13.2.2 in the CRA between United and TennCare, the parties agree that United shall not reimburse Provider based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.

6.11 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Health Plan or as prohibiting or penalizing United for contracting with other providers.

UnitedHealthcare | Networks

Payment Appendix
Fee Information Document
Representative Fee Schedule Sample for -1: as of 7/1/2022
Report Date: 06/21/2022

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

Type Of Service Description	Primary Fee Source	Pricing Level

Default Percent of Eligible Charges: 20.00%
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 40.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2022

Fixed Fees: 92507 - $40.00 92508 - $40.00 92551 - $40.00 92552 - $40.00 92553 - $40.00 92555 - $40.00 92556 - $40.00 92557 - $40.00 92567 - $40.00 92568 - $40.00 92570 - $40.00 92579 - $40.00 92582 - $40.00 92587 - $40.00 92587-26 - $34.21 92587-TC - $5.79 92588 - $40.00 92588-26 - $35.04 92588-TC - $4.96 92620 - $40.00 92621 - $40.00 95851 - $40.00 95852 - $40.00 97110 - $40.00 97112 - $40.00 97116 - $40.00 97124 - $40.00 97150 - $40.00 97161 - $40.00 97162 - $40.00 97163 - $40.00 97164 - $40.00 97165 - $40.00 97166 - $40.00 97167 - $40.00 97168 - $40.00 97530 - $40.00 97535 - $40.00 97537 - $40.00 97542 - $40.00 97750 - $40.00 97755 - $40.00 97760 - $40.00 97761 - $40.00 97763 - $40.00 99211 - $5.37

Payment Appendix
Fee Information Document
Representative Fee Schedule Sample for -1: as of 7/1/2022
Report Date: 06/21/2022

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
01953	00	ANES 2/3 DGR BRN	ANESTHESIA - PM	NonFacility	$ 40.00
01996	00	DAILY HOSP MGMT	ANESTHESIA - PM	NonFacility	$ 120.00
92507	00	TX SPEECH LANG V	MEDICINE - OTHER	NonFacility	$ 40.00
92508	00	TX SPEECH LANGUA	MEDICINE - OTHER	NonFacility	$ 40.00
92551	00	SCREENING TEST P	MEDICINE - OTHER	NonFacility	$ 40.00
92552	00	PURE TONE AUDIOM	MEDICINE - OTHER	NonFacility	$ 40.00
92553	00	PURE TONE AUDIOM	MEDICINE - OTHER	NonFacility	$ 40.00
92555	00	SPEECH AUDIOMETR	MEDICINE - OTHER	NonFacility	$ 40.00
92556	00	SPEECH AUDIOMETR	MEDICINE - OTHER	NonFacility	$ 40.00
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	NonFacility	$ 40.00
92567	00	TYMPANOMETRY	MEDICINE - OTHER	NonFacility	$ 40.00
92568	00	ACOUSTIC REFLEX	MEDICINE - OTHER	NonFacility	$ 40.00
92570	00	ACOUSTIC IMMIT T	MEDICINE - OTHER	NonFacility	$ 40.00
92579	00	VISUAL REINFORCE	MEDICINE - OTHER	NonFacility	$ 40.00
92582	00	CONDITIONING PLA	MEDICINE - OTHER	NonFacility	$ 40.00
92587	00	DISTORT PRODUCT	MEDICINE - OTHER	NonFacility	$ 40.00
92587	26	DISTORT PRODUCT	MEDICINE - OTHER	NonFacility	$ 34.21
92587	TC	DISTORT PRODUCT	MEDICINE - OTHER	NonFacility	$ 5.79
92588	00	DISTRT PROD EVOK	MEDICINE - OTHER	NonFacility	$ 40.00
92588	26	DISTRT PROD EVOK	MEDICINE - OTHER	NonFacility	$ 35.04
92588	TC	DISTRT PROD EVOK	MEDICINE - OTHER	NonFacility	$ 4.96
92620	00	EVAL CENTRAL AUD	MEDICINE - OTHER	NonFacility	$ 40.00
92621	00	EVAL CENTRAL AUD	MEDICINE - OTHER	NonFacility	$ 40.00
95851	00	ROM MEAS&REPRT E	MEDICINE - OTHER	NonFacility	$ 40.00
95852	00	ROM MEAS&REPRT H	MEDICINE - OTHER	NonFacility	$ 40.00
97110	00	THERAPEUTIC PX 1	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97112	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97116	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97124	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97150	00	THERAPEUTIC PROC	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97161	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97162	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97163	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97164	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97165	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97166	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97167	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97168	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97530	00	THERAPEUT ACTVIT	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97535	00	SELF-CARE/HOME M	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97537	00	COMMUNITY/WORK R	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97542	00	WHEELCHAIR MGMT	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97750	00	PHYSICAL PERFORM	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97755	00	ASSTV TECHNOL AS	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97760	00	ORTHOTICS MGMT &	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97761	00	PROSTHETICS TRAI	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
97763	00	ORTHOTICS/PROSTH	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	NonFacility	$ 40.00
99211	00	OFFICE/OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 5.37

Default Percent of Eligible Charges: 20.00%
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 40.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2022

Payment Appendix
Fee Information Document
Representative Fee Schedule Sample for -1: as of 7/1/2022
Report Date: 06/21/2022

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
01953	00	ANES 2/3 DGR BRN	ANESTHESIA - PM	Facility	$ 40.00
01996	00	DAILY HOSP MGMT	ANESTHESIA - PM	Facility	$ 120.00
92507	00	TX SPEECH LANG V	MEDICINE - OTHER	Facility	$ 40.00
92508	00	TX SPEECH LANGUA	MEDICINE - OTHER	Facility	$ 40.00
92551	00	SCREENING TEST P	MEDICINE - OTHER	Facility	$ 40.00
92552	00	PURE TONE AUDIOM	MEDICINE - OTHER	Facility	$ 40.00
92553	00	PURE TONE AUDIOM	MEDICINE - OTHER	Facility	$ 40.00
92555	00	SPEECH AUDIOMETR	MEDICINE - OTHER	Facility	$ 40.00
92556	00	SPEECH AUDIOMETR	MEDICINE - OTHER	Facility	$ 40.00
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	Facility	$ 40.00
92567	00	TYMPANOMETRY	MEDICINE - OTHER	Facility	$ 40.00
92568	00	ACOUSTIC REFLEX	MEDICINE - OTHER	Facility	$ 40.00
92570	00	ACOUSTIC IMMIT T	MEDICINE - OTHER	Facility	$ 40.00
92579	00	VISUAL REINFORCE	MEDICINE - OTHER	Facility	$ 40.00
92582	00	CONDITIONING PLA	MEDICINE - OTHER	Facility	$ 40.00
92587	00	DISTORT PRODUCT	MEDICINE - OTHER	Facility	$ 40.00
92587	26	DISTORT PRODUCT	MEDICINE - OTHER	Facility	$ 34.21
92587	TC	DISTORT PRODUCT	MEDICINE - OTHER	Facility	$ 5.79
92588	00	DISTRT PROD EVOK	MEDICINE - OTHER	Facility	$ 40.00
92588	26	DISTRT PROD EVOK	MEDICINE - OTHER	Facility	$ 35.04
92588	TC	DISTRT PROD EVOK	MEDICINE - OTHER	Facility	$ 4.96
92620	00	EVAL CENTRAL AUD	MEDICINE - OTHER	Facility	$ 40.00
92621	00	EVAL CENTRAL AUD	MEDICINE - OTHER	Facility	$ 40.00
95851	00	ROM MEAS&REPRT E	MEDICINE - OTHER	Facility	$ 40.00
95852	00	ROM MEAS&REPRT H	MEDICINE - OTHER	Facility	$ 40.00
97110	00	THERAPEUTIC PX 1	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97112	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97116	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97124	00	THER PX 1/> AREA	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97150	00	THERAPEUTIC PROC	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97161	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97162	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97163	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97164	00	PHYSICAL THERAPY	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97165	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97166	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97167	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97168	00	OCCUPATIONAL THE	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97530	00	THERAPEUT ACTVIT	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97535	00	SELF-CARE/HOME M	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97537	00	COMMUNITY/WORK R	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97542	00	WHEELCHAIR MGMT	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97750	00	PHYSICAL PERFORM	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97755	00	ASSTV TECHNOL AS	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97760	00	ORTHOTICS MGMT &	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97761	00	PROSTHETICS TRAI	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
97763	00	ORTHOTICS/PROSTH	MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Facility	$ 40.00
99211	00	OFFICE/OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 5.37

Default Percent of Eligible Charges: 20.00%
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 40.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2022

Payment Appendix
Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

Section 1. Definition of Terms
Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

AMA: American Medical Association located at: www.ama-assn.org .

Anesthesia Conversion Factor: The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes. In the event that any of United's claims systems cannot administer a 15 minute anesthesia time unit value, then the Anesthesia Conversion Factor will be calculated as follows:

[(Value of 15 minute Anesthesia Conversion Factor / 15) * anesthesia time unit value]

For example, an Anesthesia Conversion Factor of $60.00 (based on a 15-minute anesthesia time unit value) would be calculated to an Anesthesia Conversion Factor of $40.00 (based on a 10-minute anesthesia time unit value).

Example: [($60.00 / 15) * 10 = $40.00]

Anesthesia Management: The management of anesthesia services related to medical, surgical or scopic procedures, as described in the current Anesthesia Management Codes list attached to the Anesthesia Payment Policy located at www.unitedhealthcareonline.com .

Calculation of Anesthesia Partial Units:
Proration: Partial time units will be prorated and calculated to one decimal place rounded to the nearest tenth. For example, if the anesthesia time unit value is based on 15 minutes and if 17 minutes of actual time is submitted on a claim, then the 17 minutes will be divided by 15. The resulting figure of 1.1333 will be rounded to the nearest tenth and the total time units for the claim will be 1.1 time units.
In the event that any of United's claims systems cannot administer the calculation of partial units as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the Proration method described above.

CMS: Centers for Medicare and Medicaid Services located at: www.cms.hhs.gov .

CMS OPPSCap Rate: The Outpatient Prospective Payment System (OPPS) Cap Rate as defined in Section 5102(b) of the Deficit Reduction Act of 2005.

Conversion Factor: A multiplier, expressed in dollars per relative value unit, which converts relative values into Fee Basis amounts.

CPT/HCPCS: A set of codes that describe procedures and services, including supplies and materials, performed or provided by physicians and other health care professionals. Each procedure or service is identified with a 5 digit code. The use of CPT/HCPCS simplifies the reporting of services.

CPT/HCPCS Description: The descriptor associated with each CPT/HCPCS code.

Default Percent of Eligible Charges: In the event that a Fee Basis amount is not sourced by either a primary or alternate Fee Source, such as services submitted using unlisted, unclassified or miscellaneous codes, the codes are subject to correct coding review and will be priced at the contracted percentage indicated within this document.

Expired Code: An existing CPT or HCPCS code that will be expired by the entity that published the code (for example, CMS or the AMA).

Fee Amount: The contract rate for each CPT/HCPCS. The calculation of the Fee Amount is impacted by a variety of factors explained within this document including, but not limited to, Professional/Technical Modifier Pricing, Carrier Locality, CMS year, Place of Service and Pricing Level. The Fee Amount is calculated by multiplying the Fee Basis times the Pricing Level for each specific Type of Service.

Fee Basis: The amount published by the Fee Source upon which the Pricing Level will be applied to derive the Fee Amount.

Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule which supports the terms of the contractual agreement. This is the fee schedule for services performed in nonfacility Places of Service.

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Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

Fee Schedule Specifications: Documentation of the underlying calculation methodology and criteria used to derive the Fee Amounts contained within the fee schedule.

Fee Source: The primary or alternate entity or publication that is supplying the Fee Basis.

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Flat Rate Fee: An amount published by a Fee Source and used as a Fee Basis that is other than a RVU, such as an amount for durable medical equipment or laboratory services.

Future Payment Terms: The general description of any pricing terms which will be implemented on a scheduled future effective date.

Last Routine Maintenance Update: The effective date on which this fee schedule was most recently updated. Please refer to the Routine Maintenance section of this document for more information about Routine Maintenance updates.

Linked Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule for each specific contractual agreement. This is the fee schedule for services performed in facility Places of Service.

Modifier: A Modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code.

Place of Service: The facility or nonfacility setting in which the service is performed. This may also be referred to by CMS as Payment Type.

Pricing Level: The contracted percentage or amount that will be multiplied times the primary or alternate Fee Basis amount in order to derive the Fee Amount.

Primary Fee Source (Carrier Locality): The main Fee Source used to supply the Fee Basis amount for deriving the Fee Amount within each Type of Service category. For instance, if the Fee Amounts for a given category of codes are derived by applying a particular Pricing Level to the CMS Resource-Based Relative Value Scale (RBRVS), then CMS RBRVS is the Primary Fee Source. The Carrier Locality is designated to indicate the exact CMS geographic region upon which the Fee Amounts are based.

Professional/Technical Modifier Pricing: Fee Source-Based: Fee Amounts for Modifiers (for example, -TC or -26 Modifiers) are derived using the Fee Basis amount as published by the primary or alternate Fee Source.

RVU: Relative Value Unit as published by CMS. United uses the RVU that is used by CMS. For example, if CMS uses a transitional RVU, then United will as well.

Replacement Code: One or more new CPT or HCPCS codes that are the exact same services or descriptions and will replace one or more Expired Codes within the same Type of Service category.

Report Date: The actual date that this document was produced.

Representative Fee Schedule Sample: A representative listing of the most commonly used CPT/HCPCS codes and fees, along with other relevant pricing information, for each specific Fee Schedule ID. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Schedule Type: FFS: This is a fee-for-service fee schedule. Unless stated otherwise, the Fee Amount indicated will be used to calculate payment to you as further described within this document.

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 =F): This fee schedule follows CMS guidelines for determining when services are priced at the facility or nonfacility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule). CMS guidelines can be located at: www.cms.hhs.gov .

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Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

In the event that any of United's claims systems cannot administer the calculation of Site of Service Differential pricing as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the method described above.

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS). The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office. A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

United: UnitedHealthcare Insurance Company or one of its affiliates which is a party to the Agreement.

Section 2. Alternate Fee Sources
In the event the Primary Fee Source contains no published Fee Basis amount alternate (or 'gap fill') Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for the code, we use Fee Sources that exist within the industry to fill that gap. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS code that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source. Information about our Alternate and Primary Fee Sources can be located at www.unitedhealthcareonline.com >> Claims & Payments >> Fee Schedule Lookup >> Related Links.

Section 3. Routine Updates
Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature.

The types of routine updates, and their respective effective dates, are described below.

a. Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees
This fee schedule follows a "stated year" construction methodology. The 2020 RVU, the 2020 Conversion Factor, and the 2020 Flat Rate Fee will be locked in as the basis for deriving Fee Amounts.
Generally, any RVU, Conversion Factor, or Flat Rate Fee changes published in subsequent years by the Primary Fee Sources will not be reflected in this fee schedule except, for example, to add Fee Amounts for new codes or to replace alternate Fee Basis amounts. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.

2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

b. Quarterly Updates in Response to Changes Published by Primary and Alternate Fee Sources
United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee

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Linked Fee Schedule ID: TN 9127A - Facility

update under this subsection b. will be effective no later than October 1.

In the event that a code contains a status code of “C” (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS’ multiple procedure indicator is other than "4" and United’s multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.

2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

However, in the event that the code source has expired a CPT/HCPCS code and replaced it with a Replacement Code, United will crosswalk the fee from the Expired Code to its Replacement Code as further described below:

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II), when one Expired Code is replaced by one Replacement Code, United will apply the Expired Code's Fee Amount to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II) and United's claims data, when several Expired Codes that are always done in conjunction with each other are replaced by one Replacement Code, United will apply the sum of these Expired Code's Fee Amounts to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

The following types of codes are not included in our direct crosswalk methodology as described above:

- Temporary HCPCS codes, such as G, K, Q, and S codes
- Temporary CPT codes, such as Category III codes
- Informational codes, such as CPT Category II codes
- HCPC-C Codes, which are only used by hospitals
  Codes categorized as immunizations and injectables

If any types of codes not currently listed in the exclusions above are developed in the future, United reserves the right to make a crosswalk determination at that time.

c. Price Changes for Immunizations and Injectables
United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

The effective date of updates under this subsection c. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c. will be effective no later than October 1.

d. Other Updates
United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

Payment Appendix
Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: TN 9126A - NonFacility
Linked Fee Schedule ID: TN 9127A - Facility

Section 4. Miscellaneous
Claims must be submitted using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-9 codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers.) As used in the previous sentence, “global fees” refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

No payments will be made for any CMS additional compensation programs under this Payment Appendix, including without limitation value based modifiers, incentive programs or other bonus payment programs.

Section 5. Services Covered or Provided by Another Program
If an applicable state, federal or other program is available to provide items or payment directly to provider for specific covered services for customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program.)

For More Information United is committed to providing transparency related to our fee schedules. If you have questions about this fee schedule, please contact Network Management at the address and phone number on your contract or participation agreement. Alternatively, you may use our fee schedule look-up function on the web at: www.unitedhealthcareonline.com or contact our Voice Enabled Telephonic Self Service line at (877) 842-3210.